

PUBLIC HEALTH



LONDON: THE SOCIETY OF MEDICAL OFFICERS OF HEALTH
Tavistock House South, Tavistock Square, W.C.1

No. 6.-Vol. LXVII.

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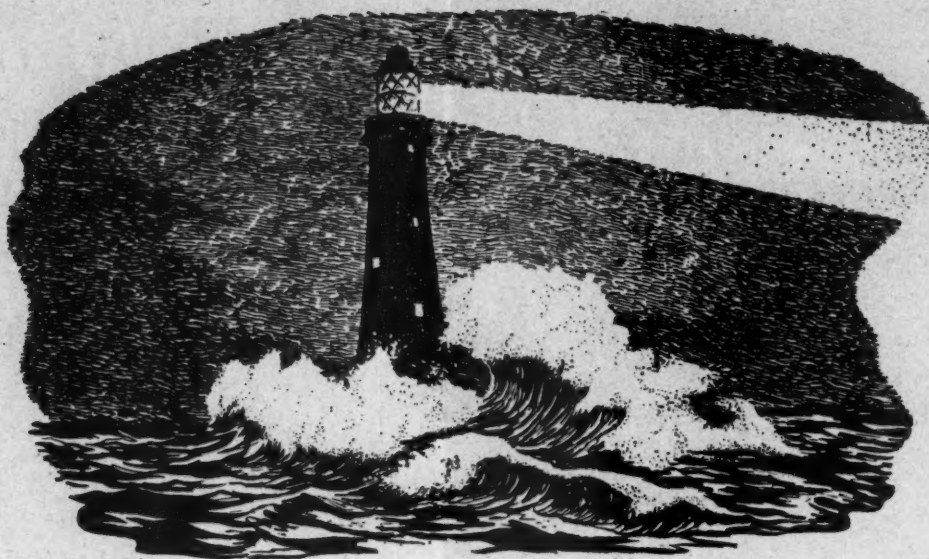
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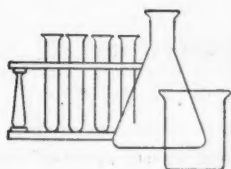
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Telegrams: Epidauros, Westcent

No. 6. Vol. LXVII

MARCH, 1954

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THE SCHOOL HEALTH SERVICE AND THE TREATMENT AND EDUCATION OF HANDICAPPED CHILDREN IN THE U.S.A.*

By PETER HENDERSON, M.D., D.P.H.

Principal Medical Officer, Ministry of Education

Through the generosity of the World Health Organisation I was given a travelling fellowship to study arrangements for the school health service and the treatment and education of handicapped children in the United States and Canada from September to December, 1952.

Although I travelled over 5,000 miles on the North American continent I saw but a small section—said, however, to have been a representative one—of the work being done for children. All that I can attempt to-night is a broad summary of the services as I saw them in the areas I visited. The World Health Organisation is in no way responsible for the views expressed.

This evening I shall confine myself, owing to lack of time, to a description of the services in the United States. At the outset I want to say that I thoroughly enjoyed my stay. I liked the Americans I met. Most of them were able and keen. They did all they could to help me and make me feel at home and I much appreciated their hospitality. Some day I should like to visit them again.

School Health Service

In the majority of areas, including most of the large towns, the service was provided by boards of education; in the rural areas, and in a few large cities, *e.g.*, New York and Buffalo, the city or county health departments were responsible. Usually, boards of education accepted no responsibility for the parochial (mainly Church) schools; in some districts the health department organised a school health service for children attending these schools.

The type and scope of the service varied widely from State to State and, indeed, from county to county in the same State. In Baltimore, for example, the health department was responsible for the school health service in the elementary schools but the board of education was responsible for it in the secondary schools. Some States, *e.g.*, New York, prescribed by law annual medical inspections, whereas in some other parts of the country medical examinations were not carried out. Even in Chicago, the second largest city in

America with about half a million school children, a school medical officer was appointed for the first time in 1950: he had no assistants and no provision had been made for the medical examination of the city's school children.

In many cities and counties four examinations during a child's school life were attempted. Almost invariably the examinations were made by general practitioners or paediatricians employed part-time. Wherever I went I was told that good doctors were difficult to recruit since most of them could earn more in private work. The general practice was to employ young men in the hope that they would remain in the service for a few years; but, usually, they resigned within a year or two. There was thus seldom continuity in the schools and often neither they nor the doctors became well known to each other.

In New York City all part-time doctors had, before engagement, to attend a pre-service course of training for five sessions a week for six weeks; during their period of training they were paid the same fee (\$10.30) they would have received per session had they been employed on clinical work. In New York, too, a team of 30 part-time "Supervisory Physicians" (they were, nearly always, paediatricians) were engaged to organise and supervise the work of the part-time doctors carrying out the periodic medical examinations; they worked under the general direction of the four whole-time school medical officers.

In many areas parents were asked to have their children examined by their own doctors in their surgeries; the board of education, or health department, supplied the doctors with a form which they were expected to complete and return to the school. The parents paid the cost of the examination and of the report. In New York City about half the periodic medical examinations were made in this way. In 1951 the school medical officer of Denver sent 20,000 forms to private practitioners, through the parents, but only 5,000 were returned, many of which "contained only a series of check marks that revealed nothing to the schools"; and I heard the same criticism elsewhere.

It is fair to say that for all practical purposes there were no school treatment clinics; children found to require treatment were referred to their private doctors and dentists.

Specialist diagnostic and treatment facilities were organised by the Crippled Children's Agencies (mostly in health departments), with federal and State grants, for "crippled" children. There were wide variations in the interpretation of the term "crippled"; in some towns and counties the term included cleft palate, speech and hearing defects, partial-sight, epilepsy, and a large number of medical and

* Address given to the School Health Service Group, Society of M.O.H., London, November 20th, 1953.

surgical conditions ; in other districts the term was restricted to children mainly with orthopaedic defects. In addition, some health departments had established specialist clinics for the indigent. But, I formed the impression that many children in need of treatment were not receiving it.

In a large number of schools the teachers (either the class teacher, the teacher of physical education or one specially assigned) were expected, periodically, to weigh and measure the children, test their vision with Snellen's Chart and give them an audiometric examination ; they were also expected to examine the children for vermin and to look for signs of ill-health among them. Many class teachers were supposed to spend the "first few minutes" of every school day surveying the children in their classes with a view to referring those who appeared to show "deviations from normal" to their family doctors. Some of the doctors and educationists I interviewed argued that since the teachers had the children under supervision all day for five days a week they were more competent than anyone else to detect "deviations from normal" and that, therefore, there was no need for a school health service. In some high schools the teachers of physical education resisted attempts to bring doctors and nurses into the schools. Nothing that I saw or learnt in America convinced me that even alert and informed teachers could replace a school medical and nursing service.

Some school doctors appeared to attach more value to the annual "nurse-teacher conference" than to periodic medical examination. I was surprised that so much stress was put on these "conferences" ; it seemed to me that frequent meetings between nurse and teacher were a vital and indispensable part of any school health service and that a formal "conference" once a year should not have been necessary.

The "counselling" services for children were also considered to be of prime importance. Many schools were so large that it was impossible for the headmasters or headmistresses to know the children personally or to be their principal advisers in school. Inevitably, in the large schools, one or more members of the teaching staff had to act as "counsellor." But, I sometimes wondered if there were not too many adults, in some schools, purveying advice—the "counsellor teacher," the "adjustment teacher," the "visiting teacher," the teacher of physical education who was often considered by his colleagues to be the "health expert" on the staff, and the psychologist ; to say nothing of the class teacher, the nurse and the doctor and, presumably, somewhere in the background, the headmaster or headmistress.

I was surprised to find that in many areas school doctors had little part in the ascertainment, placement and supervision of handicapped pupils. When a school medical officer was first appointed in Chicago, in 1950, he discovered a large number of children in the city's four special schools for physically handicapped children who were said to be disabled by heart disease and unfit for ordinary school ; on investigation, however, they were found either with a normal heart or had but slight disability and should have been in ordinary schools ; instead, they were being taken to and from the special schools by bus, given compulsory rest and treated as "delicate."

School Dental Service

In many towns and counties children were inspected annually and those in need of treatment were referred to private dentists, the parents paying the cost. In some areas treatment was provided free for a small number of children if their parents were indigent.

Some city boards of education employed dentists whole-time on inspection only. I thought that practice a sheer waste of public money. Most of the dentists were employed part-time by boards of education ; a few were employed by health departments to work in schools. There were about 200 dental hygienists employed in the school dental service.

I was told that only about 35% of the school children received adequate dental care.

The Nursing Services

In 1952 there were about 26,000 nurses in the public services of whom 6,456 were employed whole-time in schools ; most of the 6,456 had a three years' course of training and were neither trained in public health nor worked in the public health service. Often they were better paid and had longer holidays than the public health nurses, so the school health service was able to recruit nurses more easily than the public health services. Almost everyone I interviewed in public health departments was strongly opposed to the appointment of a nurse to the school health service only : it was considered that that was a narrow field of work and that often school nurses were engaged on duties that could have been done equally well by lay staff. There were no national scales of salary.

Of the 1,000 schools of nursing, 100 were university schools. I was told that the trend in America was to transfer nursing education from the hospitals to the university schools. Nurses trained at the university schools took a four (sometimes five) years' course that led to the Bachelor of Science Degree. The non-university schools generally ran a three years' course. Nurses wishing to enter the public health service usually took a post-graduate course for one year at a university school of public health : about 1,200 nurses took the course annually.

In 1947 six universities instituted an 18 months' course in mental health nursing leading to a Master's degree ; students had to be graduates and had to have practical experience in public health nursing, usually as superintendents or tutors. By 1952, 124 mental health nurses were in practice and the annual output was 20 to 25. The primary function of a mental health nurse was to advise and help the other nurses in a public health department and to maintain close liaison with the other mental health workers in the area.

In view of the importance of interesting teachers in the health and development of children, 97 teachers' training colleges had appointed nurses as whole-time lecturers on child health ; these 97 nurses were graduates who had taken the post-graduate course in public health nursing.

A recent development had been for public health nurses to combine public health with domiciliary nursing ; 70 areas had adopted this "combination service." In one county it was found that one visit in three was for bedside nursing. Some of the supervisors of public health nurses to whom I spoke said that although the system had some obvious advantages both for patient and nurse, yet there was a danger, especially with an ageing population, that there might be little or no time for health teaching by the nurses.

The Mental Health Service

In 1950 there were 1,228 mental health clinics in America ; 902 accepted children ; about one-third of the total were for children only. Several States had organised "travelling clinics" to work in rural areas. About half the clinics were in the large cities in the N.E. region, along the shores of the Great Lakes and in California. Large tracts of country had little or no service.

About 60% of the clinics were run by health or welfare departments, 27% by voluntary agencies and only 5% by boards of education ; 37% were departments of hospitals (14% in mental hospitals) ; 11% provided a diagnostic service only.

About 150,000 children (3.3 per 1,000 under 18 years of age) attended the clinics in 1949-50. It was estimated that at least one whole-time clinic was required for a population of 50,000. An investigation in Iowa appeared to show that 2 to 3% of children required psychiatric help.

About 70% of the clinics, serving 83% of the children, in 1949-50 had a team comprising psychiatrist, psychologist and social worker ; very few had a paediatrician.

In 1952, over three million dollars were made available from federal funds for mental health services other than those for patients in hospitals and institutions ; the States contributed 12 million dollars.

In 1948 (the latest year for which I could obtain statistics) over 38,000 maladjusted children received special education.

New York had 31 special classes in ordinary schools; Chicago had one residential and two day special schools, with four branches, but the residential school was mainly for delinquents.

There were probably about 2,000 educational psychologists employed by boards of education.

There was a great shortage of psychiatric social workers; the 31 training schools had about 1,000 students taking a two years' course.

A recent development had been the training of public health nurses in mental health to equip them to become mental health nursing "counsellors" to the nursing staff of public health departments.

Chicago board of education, among others, had appointed to every school an "adjustment teacher" to whom class teachers could refer children who were not making progress at school or who were "difficult."

A number of boards of education employed "visiting teachers" to visit the homes of truants and other "problem" children. Opinion was divided on the value of this service.

Some boards of education, e.g., New York and Chicago, ran their own child guidance service and employed whole-time psychiatrists, psychologists and social workers. In Chicago the service was almost wholly a school psychological one: for about 400,000 children there were 60 whole-time psychologists, two whole-time psychiatrists and one whole-time trained social worker. New York City with a school population of about a million had 10 whole-time and 10 part-time psychiatrists, 67 psychologists and 84 social workers. In New York I was told that the service was overburdened by educationally sub-normal children and by those presenting mainly educational problems.

A small number of public health departments, e.g., Erie County, employed whole-time psychologists in the maternal and child health service, but their value had yet to be proved.

So far as I could find out there were no boarding homes for maladjusted children and few special schools.

School Meals

In 1951-52 over nine million children (about one-third of the school population) had milk or meals in school. The Federal Government, through the Department of Agriculture, contributed about 95 million dollars towards the cost of school meals. In 1952 the total cost of the school meals service was 415 million dollars; the average charge to a child was 23 cents.

There were three types of school meal: (a) one giving, approximately, a third of the daily food requirements of a child aged 10 to 12 years; (b) one with a food value about two-thirds of (a); and (c) half-pint of milk: (a) attracted a higher grant than (b) and (b) a higher grant than (c).

Nutritionists (they usually had a Bachelor of Science degree in Home Economics) were employed by many State health departments as advisers to local health and education departments.

Health Education

Seven universities, including Harvard and Yale, had instituted a year's course of training for "Public Health Educators." The students had to be graduates and to have had at least three years' post-graduate experience in public health or related fields, e.g., nursing, or social work. The course led to a Master's degree in Public Health. By 1952, over 600 had qualified as "Public Health Educators."

In the schools the class teachers were expected to teach "health" in the course of their daily teaching. But, in practice, little was accomplished in many schools. In the high schools the teachers of physical education were mainly responsible, although in some the school nurses were given the chief part in this work.

Some States, e.g., New York, had passed a law prescribing instruction in health education in high schools for at least 20 hours a term for five terms; the interpretation of this "law" was often elastic. In a number of States, e.g.,

Michigan, instruction in car-driving was compulsory for high school pupils; appropriately, it was sometimes combined with the teaching of first aid.

Ninety-seven teachers' training colleges had appointed graduate nurses, trained in public health, as whole-time lecturers on the health and development of children.

Vision Testing

In many schools (even some with whole-time nurses) the teachers tested the vision of the children with Snellen's Chart six-monthly or annually. Sometimes the testing was done by nurses. In some areas, e.g., Michigan, "technicians" (often ex-nurses and teachers) were engaged whole- or part-time to screen school children for visual defects. In a number of cities and counties the Massachusetts Vision Tests were used. Children found with defective vision were referred to their private doctors or to opticians; if they were indigent financial help could sometimes be obtained from voluntary or social welfare agencies.

Audiometry

Some States had a law requiring an annual test of hearing. In many schools no test of hearing was attempted. In some areas the teachers (either the class or the physical education, or some other, teacher) did the testing. Often, however, school nurses were employed. In a few areas, e.g., Michigan, "technicians" (ex-nurses and teachers mainly) were employed whole- or part-time to carry out screening tests. In Michigan, too, members of the Parent-Teacher Associations assisted with the clerical work voluntarily on rota. Gramophone, individual pure tone and group pure tone instruments were all used, although the gramophone audiometer had been abandoned in many areas. The psychogalvanic skin resistance test was used in a few clinics.

The use of the electro-encephalograph in the diagnosis of defective hearing was being investigated.

Many children were without hearing aids who would have benefited from them.

Handicapped Children

The general "philosophy" was that handicapped children should, whenever possible, be educated in ordinary schools, if necessary in special classes; they should be within the ordinary educational framework as otherwise a "vested interest" in them might be developed. Many educationists considered it better for a handicapped child to be boarded out with foster parents near a school with a special class than that he should be "segregated" in a special school. On the other hand, some of the staffs of the special schools I visited had as strong a belief in the value of "segregation" as the most doctrinaire advocate of special schools that I ever met in England.

There did not appear to be any special boarding homes for handicapped children; Iowa University had one but closed it and boarded the children out with foster parents.

The total school population was about 30 million.

(a) *Blind*.—In 1952 there were about 5,500 blind children in about 50 residential schools, and about 1,000 in day schools; most of those in day schools were in special classes. There was a growing tendency to educate blind children in special classes in ordinary schools. In New York City, and in the State of New Jersey, for example, all blind children, except those whose parents elected to pay for them at private schools, were in special classes in ordinary schools. Some States had supervisors of the visually handicapped who visited the special schools and with the staff picked out those who were likely to do well in ordinary schools; they also visited ordinary schools with blind children, to advise the teachers. Many of the teachers in the residential schools opposed the policy of having blind children in special classes in ordinary schools. In Michigan it cost 2,200 dollars a year to maintain a blind child in the State residential school.

(b) *Partially-sighted*.—There were no residential schools solely for these children but several hundred were in the

schools for the blind. In many areas there were special classes in ordinary schools.

(c) *Blind/Deaf Children*.—Little provision was made.

Causes of Blindness.—These were studied in over 4,000 of the 5,000 blind children in special schools in 1950. It was found that in 64% of them the cause was pre-natal in origin.

The National Society for the Prevention of Blindness found that 1,148 out of 2,510 blind children (of whom it had records) under seven years of age, on December 31st, 1950, had retro-lental fibroplasia.

(d) *Deaf*.—In 1950–51 there were 16,260 deaf children in special schools and classes. In a few areas, e.g., Denver, Colorado, all deaf children in need of special education were taught in special classes in ordinary schools. As with the blind, there was considerable difference of opinion as to what was best for the child—a special class or a special school.

(e) *Partially-deaf*.—In 1950–51 3,883 partially-deaf children were in special classes in ordinary schools. I met very few educationists, and no doctor, who advocated special schools for partially-deaf children. At the Central Institute for the Deaf, St. Louis, severely partially-deaf children were admitted for a maximum period of two years; they were transferred to ordinary schools after being fitted with a hearing aid and having been taught speech-reading.

Auditory Training of Pre-school Deaf Children.—Among other clinics, interesting work was being done at the Johns Hopkins Hospital, Baltimore, the Vanderbilt Clinic, New York, and the Cleveland Speech and Hearing Clinic: I thought the Johns Hopkins Hospital Clinic outstanding. Here it was considered that if a hearing aid were worn from an early age (18 months or younger) and auditory training were given every day and all day, practically all children with a hearing loss of up to 75 decibels could be educated in ordinary schools, provided that special teaching help were given to most of those with a loss of about 65 to 75 decibels. Children with a loss of more than 75 decibels should be educated in groups of five in a special school.

(f) *Children with Speech Defect*.—In 1948 (the latest year for which I could obtain statistics) 182,344 children were known to have had defective speech. Many boards of education employed "speech correctionists"; about half of the 2,000 working in America had not completed the basic four years' course of College training that led to a Bachelor of Arts degree; several hundred other persons, without any special training, were employed by boards of education as "speech correctionists."

A growing minority of those engaged in treating children with defective speech and defective hearing believed that the term "speech correctionist" should be replaced by "speech and hearing therapist" and that speech therapists should be clinicians—as in England—and not teachers.

In view of the importance of audiology the minority opinion was that speech therapists should be equipped to carry out audiometric tests and to give lessons in auditory training and speech-reading, since in many parts of the country they were likely to be the only persons available for this type of work.

I found no evidence to show that in America the results of treating stammerers were better than those obtained in England. In neither country was there room for complacency.

(g) *Physically Handicapped Children*.—In 1951 about a quarter of a million handicapped children (the great majority had orthopaedic defects) received aid through the Crippled Children's Agencies; in that year about 700,000 children were on the Crippled Children's Registers; many were not receiving the treatment they required; and many registers, too, were very incomplete.

In 1948 (the latest year for which I could obtain statistics) 30,547 physically handicapped children were in special schools or classes, the big majority being in special classes. In a large number of districts no special provision was made. Most of the children in the special schools and classes I saw were severely handicapped. So far as I could find out there were few residential special schools other than hospital schools.

Some cities had made good arrangements for the teaching of children in hospital and at home.

In Buffalo, physiotherapists treated children who were in bed at home.

Local associations of parents of children with cerebral palsy were becoming numerous and they were putting pressure on boards of education to provide special schools and classes. Throughout the country small private schools were being opened and many of the children who were being admitted to them were ineducable. New York had four units, each with two classes, for children with cerebral palsy in four ordinary day schools in the city; the annual cost per child was \$2,200.

From what I saw and heard I formed the opinion that the treatment and education of children with cerebral palsy were not more advanced in the United States than in Britain.

Many of the doctors and educationists I interviewed were concerned at the high cost of treating and educating these children.

(h) *Epileptic Children*.—Apart from a few State institutions that admitted both epileptic and mentally defective persons, there was so far as I could find out only one special school solely for epileptic children in America—the White Day Special School, Detroit. Many children were known to be at home either with, or without, education.

There were some very fine hospital clinics for the diagnosis and treatment of epilepsy in children and Maryland and Ohio had organised a service of travelling clinics.

New York employed a social worker to visit every school in the city that had epileptics and to advise the teachers; she also visited the homes of the 30 epileptic children on home teaching. Over 1,000 epileptic children were in ordinary schools in New York City.

Epilepsy had been made compulsorily notifiable in four States (in order that the Motor Vehicle Licensing Department could be informed so that it could refuse a car licence to epileptics) but the measure had been a failure.

(i) *Educationally Sub-normal Children*.—In 1948 (the latest year for which I could obtain statistics) 108,741 children were receiving special education, almost all in special classes in ordinary schools. The size of class varied from 15 to 20 and the I.Q. range from 50 to 75. Since physically mature children would have been out of place in elementary schools, special classes had been set up in junior, and sometimes in senior, high schools in some States.

From 2 to 3% of the school population were considered to need special education but, for the whole country, only 15% were receiving it.

There was an increasing tendency for boards of education to appoint specialist teachers to visit schools having special classes for educationally sub-normal children to advise the teachers.

In many areas there was an active and determined Association of Parents of Backward Children. These associations had persuaded some States to amend the law so that low grade, ineducable but trainable, children could be admitted to special classes in ordinary schools. New York had 31 classes: the only requirement for admission was that the child was toilet-trained. This policy was causing concern in some areas where low-grade imbeciles, almost idiots, were being admitted.

The elaborate legal procedure in England for the ascertainment of educationally sub-normal children, and the exclusion from school of those found ineducable, had no counterpart in America. And, too, school medical officers in America had little or nothing to do with the ascertainment of these children.

(j) *Delicate Children*.—In 1948 there were 19,189 "delicate" children in about 550 special classes in ordinary schools. In 1951 between 6,000 and 7,000 children received convalescent home treatment through the Crippled Children's Agencies; many more, undoubtedly, were sent to holiday camps or convalescent homes by other organisations. Some of the "camp schools" were broadly similar to the English residential special schools for delicate children.

(k) *Diabetic Children*.—No special arrangements were made for them by boards of education other than home or

hospital teaching. There were no boarding homes but there were several holiday camps.

(I) *Maladjusted Children.* (See under *Mental Health Service.*)

Co-operation between Parents and School

Many schools in America had a Parent-Teacher Association. There was also a National Association with headquarters in Chicago. I was informed that some teachers were opposed to the movement but that the majority were in favour of it. Over and over again I was told that the schools belonged to the community and that parents had a perfect right to know what was taking place in them and that the teachers should welcome their co-operation. I went to a P.T.A. meeting in Chicago that was attended by over 400 parents. There is no doubt that many parents in America take the P.T.A. seriously.

I must say that I thought that the relationship between teacher (including head teacher) and pupil in most of the schools I visited was less formal than in many schools I know in England and that if I were a child I should have enjoyed it. I must also say that, sometimes, I thought that a little more formality and discipline would have improved the conduct of some of the boys and girls I saw.

I was particularly impressed by the efforts being made in many schools with handicapped children to bring parents into the school and clinic so that they could learn to cope better with their children and to continue their treatment at home. Examples of this partnership between parent, school and clinic were :-

- (a) The course for parents of pre-school blind children held annually in the Michigan State Blind School : in 1952 67 mothers, 27 fathers and 50 children lived together in the school for a week.
- (b) The nursery classes for blind children at the Upjohn School, Kalamazoo, where one mother attended in the morning and all the others in the afternoon ; they learned not only from the teacher but from each other.
- (c) The fortnight's residential course for parents and pre-school deaf children at the State School for the Deaf, Michigan ; 17 mothers and their deaf children attended in 1952.
- (d) The Children's Hospital School, Iowa, would not admit a child (nearly all had cerebral palsy) unless his parents undertook to spend at least three days in the school before their children were discharged home. On the first day they had talks from all the staff ; the whole of the second day they spent with their children watching what was being done for, and with, them ; on the third day they themselves carried out the treatment under supervision. At that school it was believed that most parents could, with help and advice, do almost as much for their children as therapists or teachers. These parents were visited frequently by specially trained public health nurses who encouraged and advised them. A study of 150 parents of children with cerebral palsy in Iowa had shown that 66% of them thought that their children would so improve that in adult life they would become self-supporting. One of the main reasons for teaching the parents of severely physically handicapped children in Iowa was to persuade them to face reality.
- (e) At the cerebral palsy clinic at the Mercy Hospital, Chicago, the physiotherapists showed the parents the movements their children should practise ; it was considered a sheer waste of time to treat a child at an out-patient clinic once or twice a week unless his parents continued the treatment daily at home.

The quality and extent of the co-operation between parents and the medical and educational services varied greatly, but what I saw convinced me that in this field we in England can learn from the Americans.

RUNNING AN ENURESIS CLINIC*

By HILARY CREWE, M.B., CH.B.

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During the past eight years I have run a weekly Enuresis Clinic at which I have treated several hundred children. It is because I feel enuresis to be a complaint better treated by the school doctor than by either the general practitioner or the consultant that I have chosen it as the subject for my address.

When I took up my present appointment the war was coming to a close. Bedding, nightwear and soap were all strictly rationed and it was perhaps for that reason that I had so many requests for treatment from the mothers of enuretic children. I was struck by the way in which they broached the subject. Instead of asking outright for what they wanted they would talk at length about tonsils or bronchitis or flat feet and then, just as I thought the interview at an end, would turn back shyly to ask if I knew "of a cure for bedwetting." Until then I had believed it to be an unimportant complaint of early childhood. Now, from their embarrassment, I saw it for what it really was, a very distressing social problem.

Finding me sympathetic, these women poured out confidences. I heard of husbands who still broke down if worried or sick ; of relatives discharged from the Forces when their incontinence was discovered ; of older sons and daughters who refused to go on school excursions or to camp because of the explanations involved. One 17-year-old boy, employed in the Ministry of Education in London, had received notice to leave the Government hostel in which he lodged because he had relapsed on the eve of an important examination.

It appeared that all these people had sought medical advice when younger. Some had had short courses of treatment and a few had been investigated. What was of interest was that all had been led to believe they would outgrow the condition. When it persisted they felt themselves abnormal and ceased to visit their doctors. It would seem that enuresis is not so much outgrown as better concealed with advancing age.

I found on searching the literature that although enuresis had been recognised from earliest times, little had been written about it until the war when the problems of Army life and of evacuation had inspired a spate of papers both here and in the United States.

Causation

There were three main schools of thought with regard to aetiology. Some blamed lack of training in infancy, others attributed it to physical and mental defects. The psychiatrists saw it as a symptom of maladjustment. My own cases fell roughly into the same three groups.

Of those who lacked training the majority were from poor or ignorant homes. Some came from problem families and toileted themselves as casually and irregularly as they fed and slept and went to school. Having been left wet and dirty in infancy they had ceased to be aware of discomfort. I rarely heard of them from their mothers who accepted their habits as normal, but they were regularly referred by teachers who found their presence in school objectionable. The attitude of this type of parent is well seen in the remark of a woman who had been visited by a school nurse in regard to her incontinent 12-year-old son. "Time enough for you to complain," she said, "when you're asked to do his washing."

There are, of course, some mothers who are to be pitied. It is a hard task to bring up a young family in an overcrowded, insanitary cottage. Where the closet is a dark, rather frightening building, standing in a communal yard and shared by neighbours, a child may refuse to use it, especially after dark. There was the same trouble with evacuees to the country who were afraid to use the unfamiliar privy middens.

* Presidential Address to the North-Western Maternity and Child Welfare and School Health Service Sub-groups, Society of M.O.H., Manchester, October 23rd, 1953.

I have known children from good homes develop diurnal enuresis rather than use the outdoor latrines at school.

Again, in some of the poorer homes the bedding may be thin. Where a child sleeps only in his vest he may wet the bed from cold.

There is a belief among the ignorant, especially of the older generation, that enuresis is natural. Any attempt to interfere with Nature is regarded with suspicion, if not fear. One mother told me that if I interfered with the flow of urine it might get damped back into her son's brain. From his appearance one wondered if the process were already under way.

A girl of 13 wet her bed rather than toilet herself before the two older brothers with whom she was compelled to share a bedroom.

Many of these simpler folk are afraid of the dark. I have found whole families sleeping with the bedroom lights on. Some mothers may be too nervous to get up to attend to a child in the middle of the night.

Over the years I have treated many of these poorer children and, although some of the parents have been impatient and ceased attendance when there was no immediate cure, the majority have cooperated well. Their chief weaknesses are a liability to forget instructions and failure to use their common sense. One mother continued to give her son a pint pot of tea when she had her own supper at 10 p.m., while carrying out most punctiliously my advice to omit his customary bedtime drink at 8 p.m.

So much for lack of training. Far more difficult to assess and treat are the different varieties of maladjustment. I have had among my patients many examples of the pampered, over-dependent child in whom the enuresis is so often accompanied by such other babyish symptoms as lalling, finger sucking and tantrums. Here the difficulty is to persuade the possessive, emotionally immature mother to recognise and correct her own defects. One of my first cases was a girl of six who had been adopted in infancy by a middle-aged woman and her younger, second husband. This woman resented the fact that she was a grandmother. She ignored her grandchildren while lavishing attention on the adopted child. The little girl grew more and more unsure of herself. She wanted to sit on her mother's knee, to be taken to school and visited each play time; she cried easily and became wet by night and by day.

Equally hard to treat is the child whose enuresis is aggressive in intent. It has been said that children express their emotions with their bladders. Many evacuees deliberately wet and soiled in order to get sent home and showed their dislike for their hosts by damaging their choicest furnishings. A 10-year-old patient of mine was placed in a good foster home following his mother's desertion of her family. He immediately borrowed and broke his foster brother's watch. When punished, he went upstairs and soiled in a corner of the foster brother's bedroom. Another child, a girl of five, has almost succeeded in destroying her father's second marriage by her persistently dirty ways.

Freud suggested that enuresis was a form of masturbation and in itself a pleasurable act. The child is intensely interested in the products of his own body. The act of micturition gives him a sense of power and creation. Forbidden to indulge himself in the day, he does so in the fantasy state between sleeping and waking, hence the frequency with which incontinence occurs soon after retiring and in the early morning.

Anxiety is probably the most common cause of enuresis. Highly strung and imaginative children break down for a variety of reasons, some easy to recognise, others more difficult. A young child may upset himself on hearing strange noises such as fireworks or crackers and may later wet his bed. The older child relapses after an operation, on starting school, or when preparing for a scholarship examination. I have had one case which turned out to be due to unexpressed fear of using the apparatus in the school gymnasium. Most serious cause is trouble in the home, as it may be impossible to correct. All that can be done is to send the child away on holiday in the hope that he will be better able to deal with his problem on his return.

Enuresis due to anxiety is invariably accompanied by other nervous symptoms, such as stammering, tics and nightmares.

There are, of course, many physical and mental defects which can be blamed as factors in the production of enuresis. So far as the genito-urinary tract is concerned the urologists have discovered a host of anatomical defects and inflammatory conditions, removal of which is said to produce cure. These include varying degrees of bladder trabeculation, urethral valves, and enlargement of the verumontanum. Of the cases I have referred for further investigation, one had hypospadias and another a congenital cystic kidney. The rest have been diagnosed as having a weakness of the bladder neck which should improve with the development of the prostate at puberty.

The bladder functions as the result of a correct balance between the sympathetic and parasympathetic nervous systems, overaction of the former producing strong bladder contractions and relaxation of the sphincter. This so-called "irritable bladder" is common among hypersensitive children. It tends to empty when only half full.

Some workers blame a hyperacid urine as having an irritant action, but alkalies seldom, if ever, produce a cure. What should be looked for is the existence of a reversal of the normal concentration of the urine. Where this occurs the bladder is flooded at night with urine of a low specific gravity. Where the specific gravity of a day-time specimen is over 1,020 a night, sample should be taken.

Of the general complaints, most commonly blamed are infected tonsils and adenoids and threadworm infestation. Both can act by reducing the general health. Enlarged tonsils and adenoids make for restless sleep and through mouthbreathing encourage thirst. Threadworms, by producing peri-anal irritation, may cause involuntary contraction of the bladder musculature.

There are some grounds for thinking enuresis an example of allergy, the bladder muscle responding to a particular allergen in the way the bronchial muscle responds to produce asthma. Several of my cases have suffered from hayfever or sick headaches. As in allergy, enuresis runs in families.

Diabetes mellitus and nocturnal *petit mal* occasionally present as enuresis. Spina bifida occulta, once the whipping boy so far as bedwetting is concerned, has now been absolved from all blame. It has been proved that over a third of normal children have spinal fusion defects.

Finally we have mental defect, a common and important cause. With an imperfect central nervous system, training can be exceedingly difficult.

Treatment

Having grouped my patients it remained to find some simple form of treatment suited to all types. It was obvious I should have to be my own psychiatrist, while common sense told me that were I to demand a full urological investigation in each case I should keep the local hospital very busy. Such "infallible" methods as the intra-theal injection of normal saline or the faradic stimulation of the perineum were also beyond my scope, though I doubt if I could have got the mothers to accept them. The best I could offer would be advice as to régime, some simple psychotherapy and medicine.

Claims have been made for over 40 different drugs including amphetamine, the barbiturates and the endocrines, but I chose belladonna as having proved the most popular. It is made up in the form of a mixture of belladonna and water. This mixture has the twin virtues of being cheap to buy—a 1s. 6d. bottle will last a fortnight—and sufficiently unpalatable to be unattractive to any child finding the bottle. Although all mothers are warned of its potential danger there is always the careless or forgetful one who neglects the advice.

Belladonna acts by reducing the rate and strength of the bladder contractions and is most valuable in cases of hypersensitivity. The text-books recommend a dose of one minim for each year of the child's age to be given three times a day and increased by a minim a day until the point of intolerance is reached. It is then reduced by a minim and continued indefinitely.

This method of administration is impracticable in out-patient practice and I have had equally good results from increasing the dose by two and a half minims at each fortnightly visit, warning the parents that, at the first sign of intolerance they must omit the first dose of the day. This rarely happens as children seem to tolerate belladonna unusually well.

The time of dosage is important. I get the best results from giving the first dose between 4 and 5 p.m., the second between 7 and 8 p.m., and the third between 10 and 11 p.m.

A useful secondary drug is dexedrine given in doses of half or one tablet once or twice a night. It can be given crushed with the medicine. I have tried trasentin, ephedrine, nicotinic acid and an antihistamine without effect.

While treatment is in the early stages I impose a strict régime, regular hours with a full 10 to 12 hours sleep according to age, no cinemas or exciting play last thing at night, no drinks within one and a half hours of going to bed. Mothers are asked to give the main meal at midday and to make the diet easily digestible, forbidding pickles and salty foods. An occasional aperient may be necessary.

Re-education is important and both the mother and teacher can help by training the child in regular habits and self-control. Raising last thing at night is essential and is ensured by giving the last dose of medicine at that time. In the case of a nervous child he should be allowed a nightlight.

Tilting of the foot of the bed is a good way of reminding the child that something is being done for him and may be effective in relieving the trigone of the weight of the urine.

A child who is physically below par can be helped by tonics or by a period in the convalescent home. Where his poor health is associated with anxiety over lessons, a period in the open air school will work wonders. A backward child can be assisted by extra coaching or admission to a special class.

It is important that the whole family shall combine in helping the child achieve success. Where the father will take his turn at administering the medicine and make it clear that he knows the child is not wilfully wet one can hope for speedy results. Punishments and scoldings must be replaced by encouragement and rewards. Siblings must be forbidden to mock at the child; relatives who insist that enuresis is natural and who undermine his confidence in cure must be put firmly into their place.

The child himself must take an interest in the treatment and not leave it all to his mother and the doctor. He is told that the medicine will make him drier while the tablets will help him wake up when needful. He must keep a calendar of wet and dry nights and bring it with him each time he comes to the clinic. He will meet other boys and girls who have the same complaint and we will see which of them has had the most dry nights in the fortnight. The knowledge that he is not alone in being enuretic has a remarkable tonic effect.

Running the Clinic

The actual administration of the clinic is simplicity itself. It is held in an afternoon and I see either six new cases or twelve old in a session. Notifications go out by post five days before. A nurse weighs and measures and tests the urine of each child as it arrives. There is usually little need to break the ice as most of the mothers are known to me, but to facilitate history taking I have a comprehensive questionnaire. Although it may look rather formidable it takes only 10 minutes to complete which leaves good time to examine the child, prescribe the treatment and advise the mother in the 20 minutes I allow for a first appointment.

I find these parents very easy to deal with and most anxious to give information, however intimate, which they feel may have a bearing on the child's condition. The really important thing is that both mother and child should feel absolutely at home and that they should treat the doctor as a friend. In that way confidence is quickly established and, in the majority of cases, cure a certainty.

I hope that what I have had to say has been of interest and that some of you may feel inspired to start your own clinics.

SANITATION IN RURAL SCHOOLS :

A Survey in the Light of the 1951 Regulations

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Types of Closet

Consideration of school sanitation must lead to reflection on those early days when order began to emerge from chaos in the disposal of excreta. The stages of the evolution of conservancy systems are described by Corfield and Parkes (1892) and by Firth (1908). The midden heap was superseded by the open midden pit; a crude privy might be erected over the pit, and eventually the regulations required that for the pit should be substituted merely the space between the seat of the closet and the floor (the privy midden). It was then an obvious improvement to insert a movable receptacle into the space and produce the pail closet. Much attention was given to means of keeping the pail contents as dry as possible and of deodorising them; hence the use of ash, peat, sawdust, charcoal or earth closets. The commercial possibilities of the treated or untreated contents as manure also engaged the scientific and administrative talents of our great-grandfathers and the low value of earth closet manure caused regret, for the presence of nitrifying bacteria made soil the most efficient substance for use in pails. With careful management, however, it could be retained and used again and again in the closet. Elaborate earth closets were invented in which the right quantity of dry earth was deposited by pulling a lever and these were considered the highest achievement in conservancy methods.

In very many rural areas the development of the conservancy systems of schools has been arrested at one or other of these stages; nor are earth closets themselves necessarily effective in schools. Even when water carriage is used obsolete systems persist as blatant demonstrations of practice opposite to that which should be taught in education on health and hygiene.

Lishman (1950) described a review of rural school sanitary provision in Hampshire in a presidential address to the School Health Service Group of the Society of Medical Officers of Health. His main conclusion was that when water carriage was impracticable the best substitute was the chemically charged pail closet. Although the Standards for School Premises Regulations, 1945, then in force, prescribed nothing as to the type of closet to be used, the Ministry of Education memorandum on these regulations expressed the view that generally the use of chemical closets was not desirable. Regulation 40 of the Standards for School Premises Regulations, 1951, which is summarised in Table I, now prescribes earth or chemical closets when no water supply under pressure is available. As Lishman emphasised, proper earth closets are rare in schools, a supply of suitable dry earth is usually unobtainable and the disposal of the contents by burying presents the same difficulties as with pail closets. In any case it cannot be the intention of the Minister of Education that Local Education Authorities should in this year of grace construct earth closets! One effect of the regulations, therefore, must be the replacement of the more primitive conservancy systems by chemical closets, as Lishman recommended. The regulations also encourage the construction of individual cesspools and treatment plants at schools where a main water supply is available.

Disadvantages of Dry Conservancy Methods

These are well known and may be briefly stated as:—

- (1) *Offensiveness* leading to reluctance on the part of children to use them and therefore to faulty habit formation, constipation and wet knickers.
- (2) *Separation* (usually) from hand-washing provision.
- (3) *Accessibility to flies*. This is of special importance where school meals are served.
- (4) *Difficulties in disposing of contents*, with further risk

* Now County M.O.H., Wiltshire.

of fly breeding and contamination of water supplies.
(5) *Bad example.* Schools should not only teach but demonstrate good hygienic practice, especially where sanitation in the local houses is poor.

It is, however, an over-simplification to suppose that closets of the most primitive types are always the worst. Methods of construction, lighting, ventilation, efficiency of maintenance and other factors are important.

TABLE I
SUMMARY OF REGULATION 40 OF THE STANDARDS FOR SCHOOL PREMISES REGULATIONS, 1951

Facilities available	Requirements of Regulation	
	Closets	Liquid waste (including that from urinals)
Public sewers and constant water supply under pressure	Water closets connected to sewer	Discharged into sewer
Water under pressure (no public sewer)	Water closets with cesspool or treatment plant	Discharged into cesspool or treatment plant
Public sewers (no water supply under pressure)	Earth or chemical closets	Discharged into sewer
Neither public sewers nor water supply under pressure	Earth or chemical closets	Discharged into cesspool or treatment plant

Extent of Sanitary Provision. Urinals and Closet Buildings.

Regulation 8 of the Standards for School Premises Regulations, 1951, lays down standards of construction and the number of sanitary fittings to be provided in proportion to the number of pupils.

The Staffordshire Survey

In 1951/52 a survey of rural school sanitation was carried out in Staffordshire to enumerate the types of sanitation in use and to assess the extent to which Regulations 8 and 40 of the 1951 Regulations were complied with and the practicability of compliance, having regard to sanitary common-sense as well as to the legal obligations imposed by the regulations.

It is impossible strictly to define a rural school, but there are 252 schools in Staffordshire which may be so regarded because they are "in the country" rather than "in the town," most of them small village schools. Of these, 238 were surveyed.

The fact that urban schools were not included in this particular investigation does not mean that little anxiety is felt about their sanitary provision. They have water closets, but some of these are of antiquated type, many are insufficient in number and many urinals and closet buildings fail to comply with the regulations.

Results of Survey.—The types of closets found and the extent of compliance with Regulation 40 are summarised in Table II.

Water Closets.—Detailed comments are unnecessary. Obsolete types are gradually being replaced, so that the days of the thunderous trough closet and the sports peculiar to it (such as "fire-rafts") are numbered; unless grossly mismanaged it at least keeps flies from the faeces.

The Battery Closet.—There are now no earth closets in Staffordshire schools, but it is possible that the special battery type of privy with a rear passage was originally designed for use with earth. Its origin is now obscure, but it may be a Staffordshire variant of the Bedfordshire and Hampshire earth-shed-battery-closets in which the same earth was intended to be used over and over again (Clay, 1929; Lishman, 1950).

It consists of a row of closet compartments with a sloping ramp beneath each seat hole down which the excreta are intended to slide into a covered brick, tile or concrete

TABLE II
TYPES OF CLOSETS IN 238 RURAL SCHOOLS IN STAFFORDSHIRE, 1951-52, AND NUMBER OF SCHOOLS NOT COMPLYING WITH REGULATION 40

	County Primary Schools	Voluntary Primary Schools	Total
Water Closets			
Individual basins and flushing cisterns ...	47	50	97
Individual basins with common flush automatically operated ...	1	2	3
Trough type with common flush ...	Nil	16	16
Chemical Closets (i.e., ordinary pails with chemical fluid or proprietary closets) ...			
...	6	7	13
"Dry" pail closets ...	7	50	57
Other Privies			
Battery type with rear passage for removal of excreta ...	17	16	33
Privy vaults ...	2	12	14
Privy middens ...	1	3	4
Unclassified ...	Nil	1	1
Earth closets ...	Nil	Nil	Nil
Total schools ...	81	157	238
Number without water closets ...	33	89	122
Of these: sewer and main water available, but no sewer connection made...			
...	3	5	8
Main water available, but no cesspool or treatment plant provided though technically practicable ...			
...	25	68	93
Neither main water nor sewer available, but earth or chemical closets not provided ...			
...	1	15	16
Total not complying with Regulation 40 ...	29	88	117

passage running behind the row. The passage has a gully, presumably for urine and to assist in washing down, and leading usually to a common soak pit with the urinal. Access by an end door enables the caretaker to shovel up and remove faeces and paper. These closets are very offensive and there is less protection of the faeces against flies than in pail closets because the urine is drained away and because the faeces are spread out. The problem of disposal by burial remains.

Privy Vaults.—These seem remarkably inoffensive and rarely require emptying (the usual interval is two to three years). The explanation is that the linings of the "vaults" have long since been fractured or lost their mortar so that they act as sieves within which the solids decompose while the liquids escape into the soil; they have come to resemble the "deep trench latrine" of military renown.

At one village school three separate vaults, last emptied five years ago but entirely free from odour and attracting few flies, lie within 25 feet of the well, which both facilitates seepage and registers the result in its water samples.

Pail Closets.—These are the largest group of closets of the so-called "dry conservancy" type. They are generally very wet from the presence of urine, but this may help to protect the faeces from flies which usually abound. In spite of very conscientious maintenance they are moderately (and sometimes very) offensive.

Cleaning the buckets and disposing of the contents is most difficult unless the district council provides a collection service. The place of disposal is often the secret of the caretaker. His garden? The school garden? A stream? The disused well? An old mine shaft? The farmyard muck heap? Who knows, and who will risk losing a good caretaker by enquiring too persistently? Indeed, who can blame him, for his task is an unpleasant one and his superiors would find

it hard to instruct him where to empty the pails. This difficulty in disposing of the faeces applies, of course, to other types than pail closets, but with pail closets where an efficient collection service is provided by the local authority this objection is removed.

Chemical Closets.—As the 1951 Regulations invest the chemical closet with a cloak of respectability and legal protection, it is important to consider how successful the existing chemical closets are. Only 13 schools in Staffordshire have them and these lend little support to the official good opinion. All are pails or cylindrical containers used with fluid intended to liquefy and sterilise the faeces. If used correctly no doubt such closets are reasonably satisfactory. It is, however, very difficult to teach caretakers to maintain them properly, the commonest faults being the use of too little fluid and infrequent emptying. The result is a pile of faeces with fluid around, but not over, it and serious dilution of the fluid with urine, resulting neither in the liquefaction of the faeces nor protection from flies. It seems that if the law is to be obeyed by the provision of chemical closets the simple container type will require very careful supervision, probably by a special "sanitary squad," if results better than those with other conservancy methods are to be achieved, and that experiment with the more elaborate kinds, with mixing of the contents by moving the lid or circulation of the fluid, is indicated.

Cesspools and Treatment Plants.—Only three schools have treatment plants; there are no cesspools. The evident difficulties in management and maintenance of these small plants do not encourage the provision of others, although it will be seen from Table II that there are at least 93 schools where Regulation 40 requires them to be provided.

They could hardly be expected to be maintained efficiently in isolated rural schools unless, again, a "sanitary squad" were employed, and if cesspools as distinct from treatment plants were installed regular emptying would be needed. This would be difficult and expensive with widely scattered schools. Also in some schools there are technical obstacles to the provision of treatment plants or cesspools, such as lack of space and impracticable gradients.

Structural Conditions.—On strict application of Regulation 8 to the 238 schools inspected only one complies in full. The most common defects are in lighting and ventilation and in having floors and walls not of impervious material and not easily cleaned. The time-honoured whitewashed brick wall is the usual form which fails to comply. It appears that lighting should include artificial light, which is sometimes difficult to provide, but daylight can usually be much improved by fitting a rectangle of glass tiles in the roof.

Shortage of closet accommodation is common and is particularly unfortunate in girls' lavatories. Separate and sufficient accommodation for teachers, school meals service staff and visitors is rarely found.

Some infringements of the regulation are trivial and some schools fail in only one way. Table III summarises the position.

Urinals.—Table III shows that 215 out of 238 lack impervious stalls and/or flushing apparatus. The materials used are very diverse; several look as if they are made from old tombstones. Many are foul and offensive and in almost every school not connected to a sewer urine is drained to a soak pit and not to a cesspool or treatment plant.

Summary and Conclusions

A survey of sanitation in 238 rural schools shows the persistence of primitive and very unsatisfactory methods of disposal in a high proportion of them, and unsatisfactory structural conditions in almost all.

Conditions are significantly worse in both respects in voluntary than in maintained schools, raising questions as to the application of Section 15 (4) of the Education Act, 1944, to compel the managers of voluntary schools to obtain controlled status, which cannot be discussed in this report.

However, the survey shows that compliance with Regulation 40 of the Standards for School Premises Regulations, 1951 (methods of disposal) and Regulation 8 (standards of

TABLE III
STRUCTURAL CONDITIONS IN 238 RURAL SCHOOLS IN STAFFORDSHIRE, 1951-52: NUMBER OF SCHOOLS NOT COMPLYING WITH REGULATION 8

Requirement of Regulation 8	County Primary Schools (81)		Voluntary Primary Schools (157)	
	Do not Comply	Do not comply	Do not Comply	Do not comply
Well lit and ventilated:				
Boys	33	48	5	152
Girls	33	48	6	151
Number of closets and/or urinal accommodation:				
Boys	73	8	132	25
Girls	32	49	28	29
Urinal stalls of glazed material and with flushing apparatus	12	69	11	146
Closets provided with doors and partitions to ensure privacy	78	3	136	21
Surfaces of floors and walls of closets and urinal compartments of impervious material easily cleaned ...	7	74	2	155

construction and the extent of sanitary provision) throughout the rural areas would involve capital expenditure to an extent almost certainly impossible under the present system of allocation of money by the Ministry of Education for minor building work on maintained schools, as well as beyond the capacity of the managers of voluntary schools not in the controlled category. Except for schools where both main water supply and sewer are available, it suggests that compliance with Regulation 40 would produce satisfactory conditions only if maintenance costs also were increased by the employment of special sanitary staff.

It seems likely that these findings are typical of many rural areas in the country and the welfare of the school children demands that the difficulties should be overcome.

Financially, the recommendations of the Select Committee on Estimates 1952-53 are of great interest as they advocate a national survey of the older schools in the country, criticise the Ministry of Education's present formula for the allocation of money to local education authorities for minor building work, and suggest that consideration be given to restricting the next year's minor building expenditure to works solely related to improvements (as opposed to the provision of extra places in schools).

On the technical side more experiment is required with modern types of chemical closet and treatment plant, but insanitation in rural schools is an additional strong argument for rural sewerage and water schemes.

Acknowledgements

I am greatly indebted to Dr. G. Ramage, County Medical Officer of Health and Principal School Medical Officer, for facilitating the survey, and to Messrs. H. Prest and W. Pembleton, County Sanitary Inspector and Assistant Sanitary Inspector, for much skilful and painstaking investigation.

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OBITUARY

Sir GEORGE SAMPSON ELLISTON, M.C., D.L., J.P., M.A. CANTAB.,
Barrister-at-Law

By the death on February 21st, 1954, of Sir George Elliston, aged 78, the Society loses its former Executive Secretary from 1919-30 (and from 1940-45) and an Honorary Fellow, and the public health service as a whole one of its best friends and counsellors.

The fourth son of Dr. W. A. Elliston, J.P., of Ipswich, who was President of the B.M.A. in 1901, Sir George was also the nephew of his namesake, Dr. G. S. Elliston, who was the first medical officer of health of that town and active in the Society. He was born in 1875 and educated at Ipswich School, Framlingham College and St. Catharine's College, Cambridge, whence he graduated B.A. in 1896. In 1897 he joined the printing and publishing firm of Sir Joseph Causton & Sons, Ltd., with which he was associated, latterly as a director, for the rest of his life. Although he was called to the bar at Lincoln's Inn, he never practised the law, but after a few years he contributed to a local government journal, which was printed by Causton's, a section on public health matters. This, when the parent journal was discontinued in 1908, survived as *The Medical Officer*, which he edited continuously until a short while ago. In World War I Elliston was commissioned in the R.A.M.C. and commanded a sanitary section with the 1st Cavalry Division in France from 1916-18, seeing much action and gaining the M.C. After demobilisation in 1919, he was invited by friends in the Society to become its Executive Secretary whilst continuing editorship of his journal. This period, during which he lived and worked at the Society's house, No. 1, Upper Montague Street, Russell Square, was a momentous one for the public health service, and with the leading members of the Society he fought strenuously to establish proper rates of salary for the rapidly growing ranks of medical officers. The outcome of the battle was really secured when the B.M.A., under wise leadership, realised that it was a bad thing for the profession to have an "under-privileged" section and the Askwith Memorandum was agreed and published in 1929. At this point Elliston asked to be released from the Secretaryship (then assumed by his son, G. L. C.) in order to enter politics, which he did by his election as one of the two Unionist M.P.s for Blackburn in 1931. He held this seat until retirement from Parliament before the 1945 election. His years in politics were very largely devoted to public health and allied subjects, including even a strong attempt to gain added super-annuable years for public health medical officers, a cause which has now been won. During the same period he devoted much time to the causes of smoke abatement and cremation. When G. L. C. Elliston was released by the Society to serve in the R.N.V.R. from 1940-45, Sir George again acted as Secretary at the time when the Council had to formulate their proposals for post-war planning and training, which he did most energetically amidst multifarious other calls on his time. In another public activity, as a member of the City of London Corporation from 1929 until his death, he served for several years as chairman of the Public Health Committee, culminating in the memorable occasion in 1948 when he presided over a dinner attended by the Minister of Health and many prominent M.O.H.s to celebrate the centenary of public health and the appointment of John Simon as the City's first M.O.H. He was knighted in 1944.

He was particularly gratified when, in 1943, he was appointed by the Minister of Health as a member of the Court of the London School of Hygiene and Tropical Medicine. As chairman of the Board of Management from 1944-48 he took a very active part in the revival of the School's death after the war, and nothing pleased him more than the creation of the Elliston scholarships for D.P.H. students.

Amongst the many positions which he held were those of vice-president of the Royal Sanitary Institute, a member of the Metropolitan Water Board, president of the National Smoke Abatement Society, vice-president of the Women Public Health Officers' Association, chairman of Council of the Cremation Society, vice-president of the Services' Group of the Society, secretary of the Central Council for Health Education during its first three years, and president of the Association of Public Health Lay Administrative Officers.

He is survived by his widow to whom he had been married for almost 50 years, and by two sons and a daughter (his second son was killed in action in Normandy on June 8th, 1944). A memorial Service will be held at St. Dunstan's-in-the-West, Fleet Street, London, at 12.30 p.m., on Friday, March 19th.

We are greatly indebted to Sir ALLEN DALEY for the following personal tribute.

"It is nearly 50 years ago since I first heard of GEORGE ELLISTON. My father had met him at a congress and was greatly attracted not

only by the man but also by his idea of starting a weekly paper for the public health service. I first met him at the Blackpool Congress of the Royal Sanitary Institute, held in July, 1914, on the eve of the outbreak of World War I. He was a very handsome young man. I can picture him now, dressed immaculately, reading a serious book in the lounge of the Metropole Hotel. From then, until the end, we were firm friends. We corresponded frequently while he was in the R.A.M.C., including the period just after the conclusion of the war when he was in Denmark. I pressed him to take on the secretaryship of the Society of Medical Officers of Health and the Society can never be too grateful to him for the predominant part he took in steering it through many difficult years. It was soon after his appointment that questions of salary and status of public health medical officers first began to be raised and he was always the wise counsellor and vigorous spokesman. He was essentially a man of affairs who understood human nature and motives and human frailties. As a prominent member of the Court of Common Council of the Corporation of the City of London and as a Member of Parliament for many years for Blackburn—another bond between us as I had been M.O.H. there—he had wide contacts and great influence. These were always placed freely at the disposal of the public health service. In 1929, when I was M.O.H. of Hull, I consulted him on whether or not I should apply for one of the newly created posts of Principal Medical Officer of the London County Council. With his own hand he wrote to me a long appraisal of the situation which turned out to be remarkably accurate and advised me to apply. But I am by no means unique in having gone to him for advice. Public health people of my generation constantly discussed with him their personal problems. His flat, over the Society's offices in Upper Montague Street, was the rendezvous for many and a place of happy memories. His knowledge of the people in public health was remarkable. He was intensely industrious and far-seeing and threw himself with vigour into campaigns for cremation, smoke abatement and district heating. He was always in the vanguard of progress.

"It is hard to realize that we will no longer be able to turn to him for help in the solution of difficult problems—help which was always given with graciousness and from knowledge distilled from a unique experience of the field of public health garnered over the 50 years that he was so intimately associated with it. The deep affection which he inspired will ever remain in the hearts of all those who knew him."

DONALD SAGE SUTHERLAND, T.D., M.D.(GLASG.)

The death occurred recently, at the age of 78, of Dr. Sage Sutherland, who was medical superintendent of Monsall Isolation Hospital, Manchester, from 1923 until his retirement in 1941. A son of the manse, Sutherland was born in Inverness-shire in 1875. He graduated at Glasgow University in 1898 and proceeded M.D. with commendation, in 1903. His early experience included a period as M.O. in the South African Field Force, 1900-01. The great part of his career was in the fever hospital service, which he joined in London as A.M.O. at the M.A.B.'s Brook Hospital, moving to the South-Western Hospital in 1906. After serving in the R.A.M.C. throughout the first world war, he returned to be Senior M.O. at the Eastern Hospital until 1923, when he went to Manchester.

Dr. Sutherland was a prominent member of the Society's Fever Hospital Group and was a Fellow from 1920 to 1942. We extend sympathy to his widow and two sons.

As we go to press, we learn with regret of the deaths of Dr. A. E. PORTER, formerly M.O.H., Reigate, and of Dr. J. MERVYN THOMAS, M.O.H., Chelmsford.

The 122nd Annual Meeting of the B.M.A. will be held in Glasgow from Thursday, July 1st, to Friday, July 9th, next. The Annual Representative Meeting will take place from July 1st to 8th. The Annual Scientific Meeting will follow from July 6th to 9th. Plenary Sessions will deal with "The Problem of Sleep," "Food and Disease," and "The Problem of Pulmonary Tuberculosis To-day." Meetings of the section of Preventive Medicine and Infectious Diseases will be held on the afternoon of July 8th and the morning of 9th.

CORRESPONDENCE

THE SHORTAGE OF HEALTH VISITORS
To the Editor of PUBLIC HEALTH

SIR,—Following on Dr. Kelman's letter about the training of health visitors in your February issue, I wish to draw attention to the fact that this valuable service is less popular than it deserves to be and is not attracting enough entrants. From many years' experience as a doctor in the Public Health Service, I can suggest some ways of increasing its popularity.

The life of a health visitor is a very hard one. She trudges the streets in all weathers to pay visits to mothers of infants and young children and also to old people living alone—often, the health visitor is invited in, but sometimes the interview takes place on the doorstep, in inclement weather perhaps—or the mother is out and the visit has to be repeated. Besides home visits, she has to attend sessions at the Infant Welfare Centres where she stands about, talking to the mothers and counselling them or helping the doctor, most of the time on her feet. Overtime (unpaid) is apt to be worked, clearing up after busy, overcrowded sessions. The hours are from 9 a.m. to 5 p.m. (with an hour for lunch), and on Saturdays, 9 a.m. to 12.30 p.m., whilst the holidays are only three weeks a year. Such things as necessary shopping, a visit to the dentist or a shampoo and haircut have to be fitted into the lunch hour somehow. I knew a luckless health visitor in a district about 12 miles from London who had big, badly shaped feet, needing specially made shoes. There were no free Saturday mornings available for the health visitors and she had to take a day off her three weeks' holiday to visit a special shoemaker in London when she needed new shoes. Comment is needless!

In one London borough where I worked as a part-time medical officer for many years before the last war, I used my influence to try and obtain four weeks' holiday for the hard-working health visitors there, whom I greatly admired. I failed, because it appeared that the clerks in the town hall would then demand (and expect) four weeks holiday too. Yet those clerks were working all day in a comfortable, warm office, smoking as much as they wanted and sustained by endless cups of tea—there was no comparison between their easy lot and that of the health visitor's hard life; and the extra week's holiday for her would have been a tacit recognition of the fact. In that borough, at least three of the health visitors had to retire before their superannuation was due, on grounds of health, and be allotted a smaller pension in consequence.

The following remedies should be adopted by all health authorities who wish to retain the services of their health visitors until the age of 65 and to fill up their depleted ranks.

- (1) *Four weeks holiday a year, instead of three.*
- (2) *Alternate Saturday mornings to be free;* the staff to take it in turns to be on duty in the office, for scarcely any visits can be paid as mothers are out shopping and the health visitor just sits in the office all the morning doing clerical work which could be done in her evenings, quite easily.
- (3) *The Saturday before a Bank Holiday to be free always* so that a long and restful week-end in the country could be spent at Easter, Whitsuntide and in August—one health visitor could be in the office for urgent calls and have a day off in the week after. Members of the staff could do this in turn.
- (4) *Salaries to be increased.*—I will not deal with this thorny subject in detail but I learn that there is a great deal of unrest in the service about it and especially as the higher grades of clerks in the Health Service are getting more money than the highly trained health visitors.

If these measures were adopted by all health authorities, I prophesy that the fine profession of a health visitor would become more popular and attract more entrants than is the case at present.

Yours faithfully,

MARY KIDD, M.B.(LOND.).

A Foot Health Exhibition, organised by the Royal Sanitary Institute and the Foot Health Educational Bureau of the C.C.H.E., is being held in the Institute's Museum at 90 Buckingham Palace Road, London, S.W.1, until Saturday, March 20th. It is open daily from 10 a.m. to 5 p.m. on Mondays to Fridays, and from 10 a.m. to 12 noon on Saturdays. The exhibition illustrates foot hygiene, the shape of footwear and shoe design, parents' responsibilities and allied topics.

SOCIETY OF MEDICAL OFFICERS OF HEALTH

STAFF OF THE SOCIETY

At the meeting of the Council held on Friday, February 19th, it was agreed to invite Dr. Frederick Hall, C.B.E., formerly County Medical Officer of Health, Lancashire, to become part-time Medical Secretary of the Society from April 1st next.

Mr. S. R. Bragg will continue as whole-time Administrative Officer and will deal with all correspondence.

Mr. G. L. C. Elliston is to continue as Editor of PUBLIC HEALTH.

COUNTY BOROUGH M.O.H. GROUP

President (1952-53): Dr. J. Stevenson Logan (M.O.H., Southend-on-Sea C.B.).

Hon. Secretary: Dr. W. S. Walton, G.M. (M.O.H., Newcastle upon Tyne C.B.).

Annual Meeting, July 10th, 1953

The annual meeting of the Group was held at Jesus College, Cambridge, on Friday, July 10th, 1953, at 9 p.m.

The President welcomed the following new members on the occasion of their first visit to the Group meeting:—

Drs. R. Mitchell (Burton-on-Trent), J. R. Murdock (Huddersfield), A. S. Semple (Liverpool), R. C. M. Pearson (Norwich), J. A. Gillet (Rotherham) and H. E. Seiler (Edinburgh).

The minutes of the last meeting (Leicester) were confirmed and the following matters arising from them were dealt with:—

(a) *Election of Scottish Members.* Agreed to invite the Medical Officers of Health of the Burghs associated with Universities, viz., Edinburgh, Glasgow, Aberdeen and Dundee, to become members of the Group, as recommended by the Executive Committee.

(b) *Recruitment of Health Visitors.* This matter was referred to the Sunday evening meeting for discussion.

The following matters arising from the joint meeting with the County M.O.H. Group at Hastings on April 30th, 1953, were discussed:—

(a) *G.R.O. Circular (M.O.H.), No. 4/1952, in respect of transfers of births, deaths and stillbirths.* Mr. Elliston reported on further correspondence with the Registrar-General whereby some modification of transfer procedure might be arranged.

(b) *Occupational Health from the standpoint of the Medical Officer of Health.* The memorandum on "Occupational Health from the Standpoint of the Medical Officer of Health," by Dr. Arnold Brown, County Medical Officer of Health, Cheshire, was circulated at the joint meeting of the County Borough and County Council Groups and additional copies were made available at the annual meeting.

Mr. Elliston reported that the Society had this matter actively in hand.

The following changes in membership were announced:—

Deaths—Drs. J. A. Kerr (Grimsby) and J. A. Cuthbert, Dundee.

Retirements—Drs. J. M. Gibson (Huddersfield), N. Gebbie (Kingston-upon-Hull), W. M. Frazer (Liverpool), V. F. Soothill (Norwich), W. E. Fitzgerald (Southport) and W. G. Clark (Edinburgh).

Resignations—Drs. W. Alcock (Burton-upon-Trent) and J. Fenton (Eastbourne).

Election of Honorary Members. The election of the following as Honorary Members of the Group was approved: Drs. J. M. Gibson, N. Gebbie and V. F. Soothill. The question of the election as honorary members of Dr. W. Alcock, formerly of Burton-upon-Trent, and Dr. J. Fenton, formerly of Eastbourne, was referred to the Executive Committee.

Honours. The Group congratulated Dr. E. K. Macdonald (Leicester) on his appointment as Q.H.P., and Dr. K. J. Grant (Great Yarmouth), on the award of the O.B.E., and also requested the Secretary to send a letter of congratulation to Dr. G. E. Godber on his appointment as Q.H.P.

Report of the Hon. Secretary for the year 1952-53. The Hon. Secretary reported that since the last week-end meeting, which was held at Leicester in June, 1952, the Group had held two joint meetings with the County M.O.H. Group: one in London, on the occasion of the annual dinner of the Society on October 23rd, 1952, and the other at Hastings, during the Royal Sanitary Institute Congress, on April 30th, 1953. The Hastings meeting was very well attended by some 51 of our own members and 29 members of the County Council Group. Many interesting

and useful points were discussed and certain matters are on the agenda for this annual meeting.

Financial Statement for the year 1952-53. The Hon. Secretary and Treasurer presented the financial statement (duly audited by Dr. Grant, the Honorary Auditor) for the year 1952-53, which was approved.

The resolution of the Executive Committee that no alteration be made respecting the procedure for electing members to the Executive Committee, was approved.

Election of Officers for the year 1953-54. The following were elected:—

President, Dr. T. Peirson (Plymouth).
Vice-President, Dr. J. Yule (Stockport).
Past-President, Dr. J. Stevenson Logan (Southend).
Executive Committee, Drs. G. W. Murray (Blackpool), J. Grant (Gateshead) and E. Hughes (Reading).
Honorary Secretary/Treasurer (and Representative on Council), Dr. W. S. Walton (Newcastle).

Payment of Expenses—Ministry Approval. The Hon. Secretary reported receipt of a letter from the Secretary of the Society concerning approval of the Ministry to payment of expenses for members attending the County Borough Group Week-end School. Recommended that the Hon. Secretary should make an early application for approval next year.

Week-end School, July 10th to 12th, 1953

The fifteenth annual conference and week-end school of the Group was held at Jesus College, Cambridge, from July 10th to 12th, 1953. Fifty-six members, Sir John Charles, C.M.O., and Dr. G. Lilico (Ministry of Health) and Mr. G. L. C. Elliston attended.

The annual dinner was held in the hall of the College on Friday, July 10th, 1953. The guests included Sir Lionel Whitby, Vice-Chancellor of the University of Cambridge, and Dr. C. G. Eastwood, M.O.H., City of Cambridge. Dr. Stevenson Logan presided over the dinner and welcomed Sir Lionel Whitby, who replied later in a most friendly and appreciative vein.

The annual meeting commenced shortly after 9.30 p.m. and continued until 11.40 p.m. Two sessions for papers and discussion were held on Saturday morning and there were further meetings at 5.30 and 9 o'clock in the evening. A special meeting for those interested in the D.P.H. was added to the programme and took place at 3 o'clock on Saturday afternoon. Two sessions were taken on Sunday morning and an "Open Forum" session was held at 5.30 p.m. and continued again at 9.30 p.m. after dinner on Sunday.

During Sunday afternoon members proceeded on a visit to other Colleges of the University and returned in time for tea and an initial meeting of "Open Forum." The President had arranged his details so well (even down to provision of a late evening cup of tea in rooms) that members of the Group were most comfortable and all greatly appreciated the delightful atmosphere of the old College. Over 40 members stayed throughout the week-end and this was the greatest number of survivors the Group had experienced. The total attendance of 59 members was a record for the Group, exceeding the previous record of 53 members who attended the York meeting in 1947.

It would be appropriate to report that the "gentle zephyr of optimism" which had pervaded the Leicester meeting continued to exercise an influence and members certainly seemed to go away with a feeling of better things to come. The thanks of the members were duly conveyed to the President, who had presided throughout in a most efficient and excellent manner. His handling of the meeting and his flashes of repartee and wit gave the meeting that special individual touch which many of us had anticipated would grace Logan's term of office.

On Monday morning the members departed to their various tasks.

Dr. Brittain, the genial Steward of Jesus College, very kindly conducted members on a short tour of the College during the one hour's relaxation allowed by the programme on Saturday afternoon.

On Saturday morning, July 11th, an address on "Mental Health and the Medical Officer of Health" was given by Dr. Ian Skottowe, Psychiatrist, Warneford Hospital, Oxford.

(A précis of this address was published in PUBLIC HEALTH, February, 1954.)

Next followed an address entitled "Cancer of the Lung: An Epidemiological Challenge," by Dr. W. Richard S. Doll, Research Unit, Medical Research Council. Dr. Doll gave a most interesting talk on this subject and brought in the possibility of work by the Medical Officer of Health in his lecture. The subject generally is well covered in his publication "Bronchial Carcinoma: Incidence and Aetiology" in the *British Medical Journal* of September 5th,

1953. The personal presence of Dr. Doll and the manner in which he presented his subject added very much to the interest of the members of the Group in this problem.

On Saturday afternoon a discussion on "The D.P.H. Curriculum" was opened by Prof. R. H. Parry, M.O.H., Bristol. He opened his remarks with a reference to the fact that there was very little enthusiasm for the D.P.H., and still less for the C.P.H. if taken alone. He thought that London University had degenerated so far as interest in public health undergraduate training was concerned and that the D.P.H. training there seemed to be more available to foreign students than to British nationals.

Prof. Parry maintained that the weakness of the D.P.H. lay in that it tried to combine in one diploma the speciality of preventive medicine with the statutory administrative requirements of a Medical Officer of Health. He felt that until these two entirely separate subjects were considered separately the Medical Officer of Health would fall between two stools and be considered neither a properly qualified specialist in preventive medicine nor the possessor of the necessary training in administration. He suggested, therefore, that the D.P.H. should be purely administrative and the M.D. in Preventive Medicine be considered as the specialist qualification.

In the ensuing discussion there seemed to be general agreement that the C.P.H. was not a great success and that the D.P.H. in its new form is generally acceptable and, in fact, with the development of part-time courses the number of entrants was increasing. The inclusion of "day books" and "elective subjects" were thought to be great improvements. Speakers in the general discussion included Drs. Paul, Parker, Macdonald, Logan, Walton, Prof. Banks and Sir John Charles.

One of the questions before the meeting was "Is there a need for a speciality when the Medical Officer of Health must be prepared to advise on general matters and put on the overcoat, as it were, of 'medical administration'?" The meeting did not come to any particular conclusions but the discussion showed that there will be many difficulties in making particular recommendations regarding changes in the D.P.H. examination or any substitution for the D.P.H. A further space of time is necessary to decide what are the changes in the duties of the Medical Officer of Health before a further curriculum specification could be laid down for the D.P.H.

On Saturday evening an address on "The Veterinary Approach to Public Health" was given by Mr. H. G. Mathews, Institute of Animal Pathology, University of Cambridge, who gave a most interesting and stimulating address. He commenced by comparing animals and mankind and pointed out that the former had a market value, but they had no specialist hierarchy to look after them as have the general public. The animal world had no rapidly ageing population problems. Those associated with this world did not meet malingering or neuroses. There was just no need for psychiatrists in their work of attending animals. He thought that perhaps some animals were rather superior in intellect. Housing was not a social or a political objective in the animal world and he went on to make further comparisons not to the advantage of man.

The speaker then approached the subject of specific infections and he was rather inclined to blame man for a large proportion of illness which occurred among animals. He described the machinery for eradicating bovine tuberculosis from cattle and stated that 40% of the herds are now free and are living under conditions where they are likely to remain free from bovine tuberculosis. The numbers of attested herds were increasing rapidly, and perhaps just as much as some medical officers might wish for animal contact of humans to be kept to a minimum, he for his part wished that human beings would keep away from the animals.

Mr. Mathews then discussed brucellosis and recommended vaccination. Rabies, anthrax, ringworm, orithosis, leptospira and salmonella strains were then reviewed, particularly with reference to contact cases and, finally, he gave a most excellent short résumé of points in connection with meat inspection.

Discussion: The following members contributed to the discussion: the President, who referred to tuberculosis in dogs, Dr. Grant (Gateshead), Dr. Macdonald, who criticised sausage production, Drs. Warin, Parker, and Burnett. Matters further discussed included baby chimpanzees, elephants in zoos with typhi-murium infections, and psittacosis.

The next paper, on "The County Borough Medical Officer of Health," by Dr. W. S. Walton, M.O.H., Newcastle upon Tyne, was published in PUBLIC HEALTH, February, 1954.

In the discussion Prof. Parry paid tribute to the speaker on his paper and on his optimism, but he himself felt that they should only be as optimistic as conditions warranted. Prof. Parry followed with his short paper on the same subject. "As the result of our complaints," he maintained, "the Ministry of Health has been

aroused to give the Medical Officer of Health more support. If this support continued our prestige would also improve." The question of loyalties was important. Should the Medical Officer of Health be a medical man first and a public health worker secondly, or vice versa? He thought "purpose in life" tied two people together much more than "academic qualifications" and he referred once again to the desirability of forming an Association of Public Health Workers in this country. He affirmed his continued belief in Local Government and in the good work of the Medical Officer of Health. The National Health Service was the only way available at the time it was brought into being but the mode of introduction had left a house divided among itself. Dr. Parry referred to the speaker's quotation of paragraphs by Dr. Green in the Chief Medical Officer's 1950 Report. Dr. Parry had always thought that "the Medical Officer of Health should be the friend and confidant of general practitioners and act as adviser to his public," and he thought that the quotation was very apposite at the moment.

Dr. Paul, the President, Dr. Galloway and others followed in the discussion. Dr. Paul in his contribution referred to the dexterity of a Welsh half-back and to Moná Lisa and Sonia Henje, though whether he was comparing Prof. Parry with the two ladies was not quite clear. Dr. Paul did feel, however, with the speaker, that the Ministry might help further with the co-ordination of the three branches of the National Health Service, though not by exercising detailed executive control.

Sir John Charles congratulated the speaker on his discursive history of the development of the Medical Officer of Health. He felt that the Ministry should tend to be "advisory" and not executive. He referred at some length and in a most helpful vein to some of the things which he thought Medical Officers of Health should be considering nowadays.

The President thanked Sir John sincerely for his contribution. Dr. Logan then proposed the vote of thanks to the Secretary and to Prof. Parry. He has since decreed that reference be made here to what he calls the "noble work" of the Secretary, who on the Saturday after keeping records of five sessions lasting over seven hours, delivered the principal address at the sixth session and recorded the proceedings which had commenced at 8.45 and terminated at 11 p.m.

On Sunday, July 12th, a symposium on "The Cambridge Home Care Service" was given by Professor A. Leslie Banks, Department of Human Ecology, Cambridge University, and Mr. B. M. Truscott, Surgeon, Mr. J. A. Beardsall, Secretary, and Miss Kidson, Almoner, Addenbrooke's Hospital, Cambridge.

Professor Banks drew attention to certain American schemes, including the Montefiore Hospital arrangements for relieving chronic sick beds by providing a Home Visiting Service from the hospital. Cambridge Home Care and Nursing Service was started as a scheme for acute cases only and was instituted by the Board of Governors. It included 30 patients in the initial stages and home helps were arranged for 16% of discharges and home nurses for 144 cases. The saving was the equivalent of four or five bed days per week for each case. The scheme had been working some five months and 154 cases had passed through. The hospital authority provided the home help in the first stages but financial difficulty was encountered later. Dr. Banks outlined further details of the scheme and gave some figures of costing.

Mr. Truscott listed certain advantages and disadvantages of the scheme from the point of view of a surgeon. The advantages include :—

- (1) Economy in bed days and cost to hospital and a revision of the waiting list. He himself was confronted with a waiting list of 300 hernias, for example.
- (2) For the patient, convalescence at home is usually best.
- (3) The earlier return of the patient to mobility.

The disadvantages are :—

- (1) Increased strain on the family resources.
- (2) Constant care was needed in the early stages. Occasionally there might be a risk of secondary haemorrhage.

Types of Cases : Mr. Truscott found that the most suitable cases were "cold" cases, such as hernias, appendixes and gynaecological, and the unsuitable cases for early discharge were those needing specialised care or specialised apparatus, cases which were heavy and which were suffering from some complications. Other "snags" which he had encountered were the fears of the relations and perhaps the selfishness of some, the distrust or, occasionally, the dislike of the General Practitioner for extra work, and the fear of litigation. Surgical difficulties likely to be encountered include latent sepsis, pulmonary embolism, resistant streptococcal strains developing in hospital.

Planning : In planning, there must be some basic scheme to be borne in mind ; for instance, admission day one, operation day two, discharge day four, or later. There must be discussion with the General Practitioner, the surgeon and the district nursing service.

Mr. Truscott's contribution was most interesting and here seemed to be a surgeon who was only too keen to work in close contact with the local authority outside in the field.

Miss Kidson, Almoner : Miss Kidson was the Almoner in the team and her duties were the arranging of home nurses with the local authority and keeping in close contact with the General Practitioner and the local authority on other matters. The Almoner sees the patient in hospital and the relatives and may ask the Health Visitor to call and consult with the General Practitioner wherever possible. She also might call in assistance from the voluntary societies. Home difficulties arose from bad housing and personal difficulties in home conditions, and she also drew attention to the difficulties of supplying sterile dressings. Miss Kidson made a plea for better cooperation between the General Practitioner and the local authority.

Mr. Beardsall spoke from the point of view of the hospital administrator and wished that a much greater use of beds could be made and the hospital costing could be reduced. He also would favour closer contact between the General Practitioner, the district nurse and the hospital.

Discussion : It appeared generally from the discussion that many members had experience of schemes providing contact between the hospital and the district nursing service and other services of the local health authority. The following members spoke in the discussion : Hebblethwaite (with reference to sitters up), Parker (loan equipment), Warin, Harvey and Walton (refresher courses), Macdonald (the legality of the use of free moneys for home help and home nursing services by hospitals), Keddie and Paul.

In replying to the discussion Mr. Truscott hoped that the district nurses would go more to hospital on more occasions and see the almoners, sisters and perhaps patients. He thought that there was a great chance for cooperation and all should work to the end in getting the patient home as soon as possible because of the great psychological benefits.

An address on "Housing and Family Life" was then given by



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Professor J. M. Mackintosh, Professor of Public Health, University of London. As usual, he gave a most delightful, philosophical, sincere and homely address and with appropriate references to his recently published book *Housing and Health*. He discussed the purpose of the home, the desirability of living in a structurally separate dwelling, biology of the home, and the sense of satisfaction which is associated with security, of family sharing in the group and in the growth of the home. One of his aphorisms which attracted attention was "it is not necessary to fit the family into the house but to fit the house round the family." We seemed to persist in building houses of yesterday's standard for to-morrow. The control of housing appeared to be in the hands of elderly committees and councillors who, acted for safety rather than for experiment, and showed reluctance to use new techniques and failure to appreciate good planning.

The needs of the family with regard to space, the unnecessary variation of specifications for ordinary household structures and utilities were subjects of discerning comment by Dr. Mackintosh. He later discussed the workshop of the household and thought that the Medical Officer of Health should be much more active and associate himself with the planning of houses and the arrangement of rooms and of changes which occur in the household as the children grow up.

Members contributing to the discussion included Drs. Logan, Parkman, Grant, Thompson, Irvine and Mr. Elliston.

In closing the Sunday morning meeting, the President stated that he wished to thank very sincerely the visiting speakers, Dr. Doll, Dr. Skottowe, Mr. Mathews, Professor Banks, Mr. Truscott, Miss Kidson, Mr. Beardsall and Professor Mackintosh. He thought that the addresses had been of very high calibre and had brought much of interest to the talks. The President thanked Sir John Charles and Dr. Lilico for supporting the meeting. Sir John had brought into the discussion much of a helpful nature, particularly regarding the D.P.H. and the future position of the Medical Officer of Health, and while he would not be officially recorded in detail, members were very grateful to him for his continued interest and for informal conversations which they had been able to have with him.

On Sunday evening there was an "Open Forum," which this year was one of the best ever. Two full sessions were devoted to the subjects raised by the members and even then discussion could have gone on much longer, but the President had to close the meeting because of the late hour. The sessions lasted from 5.30 to 7 p.m. and 9.30 to 11 p.m.

Grant of Great Yarmouth gave an impromptu address on the emergency measures adopted during the East Coast flooding in the Yarmouth area. It seemed that the Yarmouth Health Department were alive and in conjunction with other departments had provided a very good emergency service. Grant outlined some of the emergency arrangements and his graphic description of the order in which volunteers appeared rather amused the members. The order ran roughly as follows: (1) a few "Tom-mies" anxious to help and apparently with no claim of financial reward; (2) the British Red Cross Society; and (3) the various town organisations. The B.B.C. were useful, but the Press generally confined themselves to looking for good stories and pictures.

Others joining in the discussion on flood emergencies were the President, who drew attention to the necessity for the supply of dry bedding and the difficulties of arranging for clearing and cleaning homes after the flood water had receded. The R.A.F. had been most helpful in the Southend area. He also paid a sincere tribute to the Essex County Council arrangements. Harvey of Canterbury also spoke and drew attention to the potential "danger" of receiving gifts of whisky over 2 oz., which is apparently an offence against the Excise Law.

Out of this discussion arose discussion of other emergencies. Lilico quoted the Watford, Galloway the Doncaster, and Walton the Newcastle train disasters, and the emergency arrangements in respect of each case were outlined, and discussed.

Group Officers: Members were not very taken with the duties of this officer as suggested by the Ministry of Health and the Home Office. Liaison with the Medical Officer of Health did not seem to have been seriously considered. Drs. Semple and Keddle spoke of other Civil Defence administrative arrangements for the Medical Officer of Health.

Slum Clearance and Housing Generally: Procedures possible under current day conditions were reviewed. It was felt that the housing lists were now getting out of hand and had become almost a farce. Dodd (Nottingham) enquired as to how far local authorities were letting these lists grow and accumulate. The effects of rent restriction on repairs were seriously concerning many members. Galloway of Wolverhampton referred to reconditioning and suggested that medical officers of health should impress their committees with the necessity for reconditioning.

He quoted reconditioning schemes which had taken place in Wolverhampton, and which had raised economic rents from 7s. to 17s. 6d. a week after a house had been upgraded. He had asked the tenants on central estates of special standard priority whether they would prefer to remain and pay 10s. or 12s. 6d. more a week or go to suburbs at 27s. 6d. or so a week and the answer had been overwhelming in favour of remaining. Other members, including Dr. Parkman, were a little doubtful as to the long term results because these houses are not converted entirely to modern standards and might not be satisfactory. Peirson referred to the five-year programme of Plymouth, and Yule to one of redevelopment in Stockport. The President referred to the French policy of rebuilding on old layouts. Thompson, Neill, Grant, Burnett, Macdonald and Rennie and Irvine also referred to schemes in their own county boroughs. Gebbie pointed out that in many cases where slum clearance occurred only one-third of the displaced residents would be able to go back on the same site under modern standards, unless, of course, there were multi-storey buildings. He pointed out the danger of decay at the heart of cities while they were spreading out at the periphery and beyond.

Other members referred to the bigger grants obtainable under the Town and Country Planning Acts than the Housing Acts and that the local authorities might prefer to go to work under the legislation regarding the former more than under the latter.

Transferable Deaths: This raised considerable discussion but it is covered fairly well in the minutes of the Council of the Society where further discussion took place after the reference from the County Borough Group.

Further Subjects: Parkman of Eastbourne asked for information regarding *Cl. Welchii* and meat products and asked whether members with experience of meat contamination with such organisms would write to him.

Lawson referred to diphtheria immunisation and payment of general practitioners at the rate of 5s.

Penicillin Sensitivity: The Ministry's circular was considered and the absence of reference to the use of gloves was pointed out. Varying practices seemed to be in use in the various county boroughs and the question had raised itself administratively in a few of the southern boroughs and especially in the case of Brighton. Members contributing here included Irvine, Walton, Semple and Burn.

Cream: Parker (Brighton), raised the points that firstly milk production standards on farms were not of an adequate standard and needed more supervision and secondly that, by definition, cream is not milk and is, therefore, excluded from the legal requirements of areas designated for milk production. This means that the designation scheme is nullified by the permitted sale of untreated cream. It was suggested that the first point should be investigated by medical officers of health, and that the second point needed amendment of the national legislation.

Owing to the lateness of the hour, two or three matters, including recruitment of Health Visitors, were held over.

The proceedings closed with a hearty vote of thanks to the President. The members had worked very hard and, in fact, meetings had gone on continuously during the whole of the week-end with the exception of a short time on Sunday afternoon. The President's excellent organisation was demonstrated by the smooth working throughout the week-end. Members will not forget very readily the happy time they had in residence at Jesus College, Cambridge. Logan, in replying, thanked the members very sincerely. He had enjoyed organising the week-end and he felt that there was ample reward in the success of the meeting and the good feeling which had obtained throughout. He wished specially to thank Dr. Lilico of the Ministry of Health, who had attended all the meetings and who had been so patient and so diplomatic and so helpful over points which had arisen during "Open Forum."

DENTAL OFFICERS GROUP

President: Mr. S. B. Newton, L.D.S.

Hon. Secretary: Mr. J. F. A. Smyth, L.D.S. (P.S.D.O., Gloucestershire).

Annual General Meeting

The Annual General Meeting of the Group was held at Tavistock House South, on Saturday, July 18th, 1953, at 2.15 p.m. The meeting opened with Mr. K. Batten, the retiring President, in the chair. Fifteen members of the Group were present and apologies for absence were received from Miss J. Forrest, Messrs. E. Kew, A. G. Smith, K. C. B. Webster and Dr. A. T. Wynne. The chairman referred to the recent death of Mr. W. W. Dawe, a popular and much respected member of the B.D.A. sister group, who had frequently attended meetings of the Society. The meeting stood in silence for a moment in respect for his memory.

Report of Chairman of the Group Council. Mr. J. V. Bingay said that the Group Council had met three times and had dealt with many matters of prime importance. Claims for improved remuneration for whole- and part-time dental officers had been presented to the Dental Whitley Council. The revised School Health Service and Handicapped Pupils Regulations had been considered and certain alterations had been included in the final draft which improved the position of the School Dental Service. The Education (Miscellaneous Provisions) Bill had passed through all its stages and was expected shortly to receive the Royal Assent. The subject of Preventive Dentistry had been actively dealt with and the U.K. Mission to North America to study fluoridation had issued its report. Information was being sought regarding the Local Government Superannuation Bill. In conclusion, Mr. Bingay thanked the officers of the Group for their support and in particular praised the work of the Hon. Secretary, Mr. J. F. A. Smyth, whom he described as a tower of strength.

Report of Hon. Secretary.—Mr. Smyth said that there had been three meetings during the year and the average attendance had been 20. Representation of the Group on important Committees had been secured, namely that with reference to economies in the National Health Service, the Society's Research Committee and the Royal Sanitary Institute's Fluorides Committee.

The Hon. Treasurer, the Hon. Membership Secretary, and the Hon. Editor of Transactions also gave an account of their stewardship during the year.

The Election of Officers was as follows: *President-Elect*, Miss A. S. Stewart; *Vice-Presidents*, Messrs. K. Batten, P. G. Oliver and K. C. B. Webster; *Hon. Treasurer*, A. G. Taylor; *Hon. Secretary*, J. F. A. Smyth; *Hon. Editor of Transactions*, J. Fletcher; *Hon. Membership Secretary*, M. Cohn; *Members of Group Council*, Miss W. M. Hunt, J. C. Robertson, C. H. Rubra, E. Underhill; *Hon. Auditors*, Miss W. M. Hunt and W. L. Cooper-Jones.

Valedictory Address

Mr. Kevern Batten said that his address would be a short one. It was now the time for the new President to take the floor and to allow him to retire gracefully. When he looked back he was amazed at the great improvement that had come about in the school dental service during the past few years and not only from the monetary point of view, but also in environment. He would still, however, wish to see greater liaison between those engaged in the various branches of National Health Dentistry. He hoped to see more hold on the pre-school child. How to get them to the clinic was a big problem but it must be overcome, otherwise the service would be always chasing its tail. Another weakness of the service was the lack of opportunity given to the good clinician. The only way to promotion in the past had been by becoming an administrator. Greater liaison with the hospital service might be the answer. He thanked the members and officers of the Group for making his year of office such a happy one. He then presented Mr. S. B. Newton with the Presidential Badge and installed him in the Chair. He wished him a happy and successful year of office.

Presidential Address

Mr. S. B. Newton thanked Mr. Batten for his kind remarks and said his first pleasant task was to decorate him with the past-Presidential Badge. He had, he said, been a general dental practitioner all his life, but had at the same time held a number of part-time appointments in the treatment of children. He felt that much valuable research work might have been done had one had the time to devote to it. At a residential school where he had worked for some 30 years he had been struck by the freedom from interstitial decay which the children enjoyed. He had been about to embark on an investigation into this problem but, unfortunately, the war had supervened. He had been a member of a B.D.A. Research Committee and had suggested that an investigation might be made into the reasons why the teeth of residential school children were so much better than those of school children generally. He had been asked whether his statement as to the relative freedom from dental caries was supported by radiographic evidence. Later he had obtained permission for bite-wing x-rays of the children's teeth to be taken, but when only 28 had been filmed the war had broken out and the children had been evacuated. He had brought with him the films which had been put away since 1939. The films with very few exceptions had confirmed his earlier findings in regard to the absence from decay.

The children remained at the school for varying periods and the older ones had been there for possibly up to 8 or 10 years. They were of the type that were normally found in any elementary school and had for a variety of reasons been taken into the care of the school. They were living in the country under good conditions, were well housed, clothed and fed, had good facilities for



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out-door games and had their own swimming bath. In athletic competitions with local schools they were usually the winners. Every child had a toothbrush and those in charge saw to it that they made good use of it. If research could show that their apparent lack of dental decay was due to the conditions under which they lived, then it should not be outside the bounds of practicability to reproduce similar conditions in the ordinary homes of the mass of the population. There was room, he thought, for some investigation into how far the drinking water supply affected the teeth. In the case of the children he had been discussing their water had for many years been drawn from their own artesian well, but during the past 20 years this had been supplemented by water from the main district supply. He had much enjoyed the unrestrictive nature of the work with these children. The majority of them came into the school at about the age of five and remained until they were about 15. There had, in consequence, been a wonderful opportunity for spotting likely irregularities early and taking preventive measures. New children often arrived with interstitial decay between the first and second deciduous molars and it had become a routine practice to extract the first deciduous molars and to fill the mesial cavities in the seconds. If later there had not been room for the first premolars to erupt the extraction of the deciduous canines and later of the first premolars gave room for the permanent canines to erupt. This practice had once caused his orthodontic friends to hold up their hands in horror, but now the pundits of the West End were not averse from carrying it out. He thought that many cases which later became orthodontic problems would never have done so if a little intelligent anticipation had been exercised and he thought it very important that anyone embarking on school dentistry should have the training to spot the jaw that did not conform to the normal at an early age, and to keep the case under constant observation with a view to carrying out early appropriate treatment. He thought one should not be too hide bound in regard to the treatment of irregularities of the teeth. He had once had to extract an upper lateral incisor in a boy of 16, which had become septic. A few months later he had extracted the corresponding lower tooth. After 18 months the space in the upper jaw had practically closed and the necessity for wearing an artificial denture had been avoided.

He had mentioned these few cases in order to emphasise that the removal of a tooth or two at the right moment was not the terrible thing it was often held out to be, but that all the same it had to be done with some knowledge of the likely end result. It was for these reasons that he was certain that the right place for treating children in this country was in the school clinic under people properly trained for the work and to whom the advice of a consultant orthodontist was available.

A vote of thanks to the new and retiring Presidents for their addresses was proposed by Mr. H. B. Fleming and seconded by Mr. J. C. Robertson and carried by acclamation.

SCHOOL HEALTH SERVICE GROUP

President: Dr. Mary L. Gilchrist (Dep. M.O.H., Leyton, M.B.).

Hon. Secretary: Dr. A. A. E. Newth (Principal S.M.O., Nottingham, C.B.).

Hon. Assistant Secretary: Dr. C. W. Anderson (Sen. M.O., Cardiff, C.B.).

Ordinary Meeting, October 16th, 1953

The first Ordinary Meeting of the session was held on Friday, October 16th, 1953, at 4.30 p.m., in the Friends' Meeting House. The chair was taken, in the first instance, by the retiring President, Dr. C. L. Williams. About 40 members were present.

Dr. Williams said that it was a very real pleasure to him to hand over the Presidency to Dr. Gilchrist who had won so warm a place in the hearts of the members of the Group. In receiving the Badge of Office, the new President spoke of the honour she felt to be chosen to wear it, particularly as she was the first woman to do so.

Honorary Secretary's Report.—The Honorary Secretary reported that the Council of the Group had met that morning and had discussed, amongst other matters, Accommodation for Medical Inspection in Schools, the Distribution of Ministerial Circulars, Form 4.R.T.C., the Salaries of School Medical Officers, and the titles Principal School Medical Officer and Principal School Dental Officer. They had also given considerable attention to the question of children with defective hearing, and the use of the Sweep and Gramophone Audiometry.

New Members.—The following fellows of the Society were elected as members of the Group: Drs. Lily Arratoon, Michael J. Collins, Mary J. Fleming, Irene Hargreaves, Winifred M.

Hiscock, George M. Reynolds, Margaret Steane and Hedwig Symonds.

Presidential Address.—Dr. Mary Gilchrist then gave her Presidential Address on "The Changing Face of School Medicine." Founded on her experience as a field worker in schools and clinics, and not on the standpoint of an administrative officer seated at a desk, her remarks were most stimulating to her audience by the freshness of her outlook inspired by her faith in her calling.

Dr. Henderson, in proposing a vote of thanks, expressed in the warmest tones the appreciation of the meeting and was seconded by Dr. Powell of Walthamstow. (The address will be published in a subsequent issue of PUBLIC HEALTH.)

Joint Meeting with Medical Officers of Schools Association, November 20th, 1953

A joint meeting with the Medical Officers of Schools Association was held on November 20th, 1953, at the Rooms of the London Medical Society, Chandos Street, to hear Dr. P. Henderson, Principal Medical Officer of the Ministry of Education, on his recent visit to America. Dr. J. E. Underwood, C.B.E., President of the Association, was in the chair, accompanied by Dr. Mary Gilchrist, President of the Group. About 80 persons were present. Before the meeting, members were entertained to tea by the Association.

Dr. Underwood, welcoming the Group, said how pleased he was that the success of the first meeting, a year ago, had encouraged the two organisations to come together again this year. It was an extra pleasure to him as the speaker was his successor at the Ministry.

Dr. Henderson then gave his paper, which is printed on other pages of this issue of PUBLIC HEALTH.

The attention given to his remarks was shown by the large number of questions put to him by his audience.

After a vote of thanks had been proposed by Dr. Smith, on behalf of the Association, and Dr. Cohen, on behalf of the Group, Dr. Underwood said that it was clear that this joint meeting was establishing itself as an annual event. Dr. Gilchrist, in thanking the Association for their hospitality, said that next year they must be the guests of the Group.

NOTICES

METROPOLITAN BRANCH

President: Brig. A. E. Richmond.

A joint meeting of the Branch and of the Medical Society for the Study of Venereal Diseases is to be held in the Lecture Theatre of the Royal Army Medical College, Millbank, London, S.W.1. Mr. A. H. Harkness, F.R.C.P., and Dr. Claud Nichol, M.R.C.P., will open a discussion on "Non-specific Urethritis." Any member of the Society will be welcome.

F. M. DAY,
Town Hall, Hammersmith, W.6.
Hon. Secretary.

Refresher Course for M. & C.W. Medical Officers, London, April 5th to 10th

There are still vacancies for this Course, of which details were given in PUBLIC HEALTH, February issue, page 71. The Course runs from Monday morning, April 5th, to Friday, 10th, inclusive—fee four guineas. Applications should be sent as soon as possible to the Administrative Officer, Society of M.O.H., Tavistock House, Tavistock Square, London, W.C.1.

OFFICIAL NOTICES

City of Nottingham Education Committee

Applications are invited for the post of Deputy Principal School Medical Officer on a salary scale of £1,050 × £50 to £1,400 per annum.

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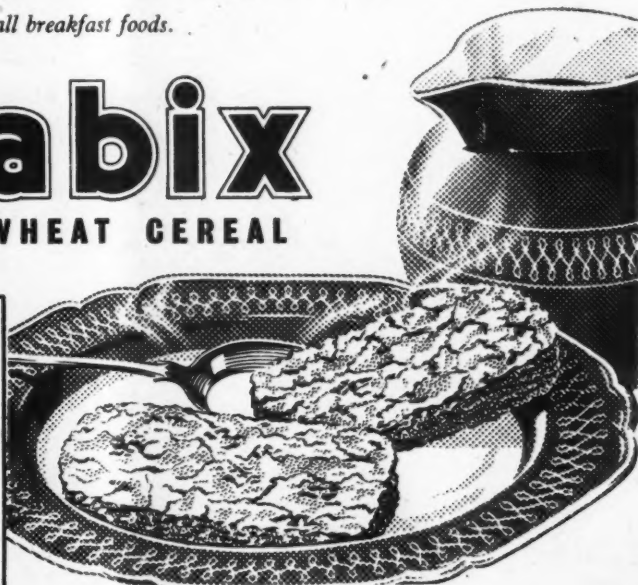
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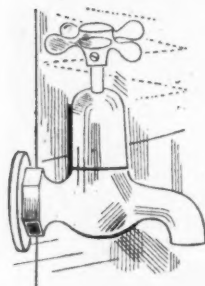
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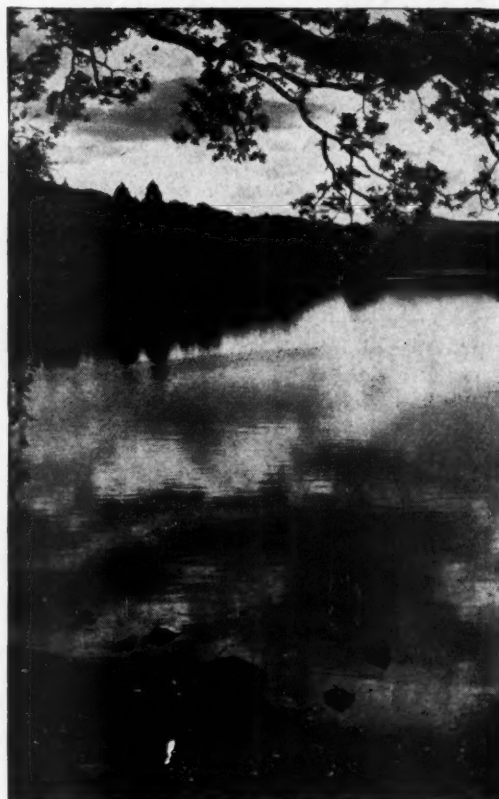
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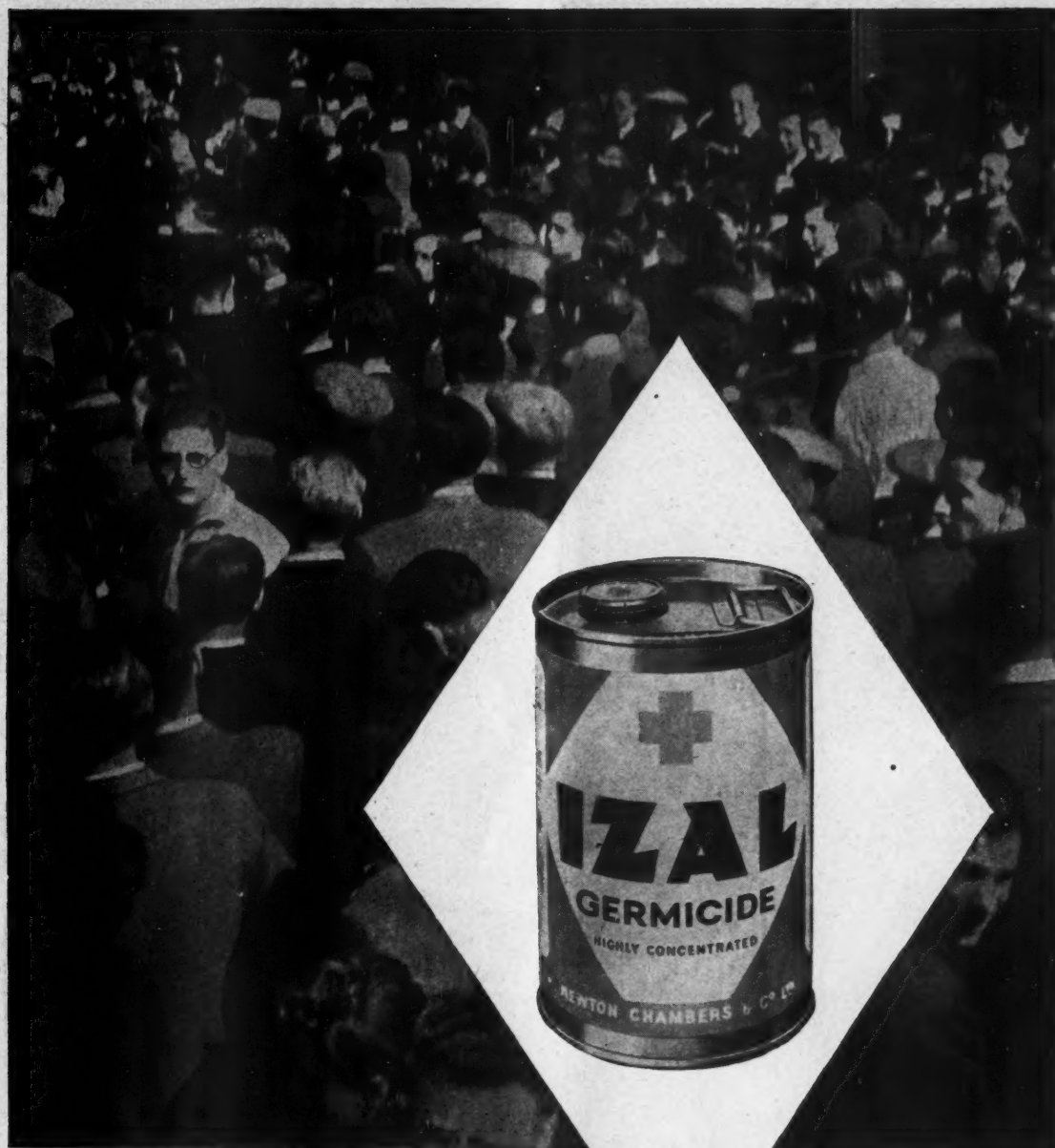
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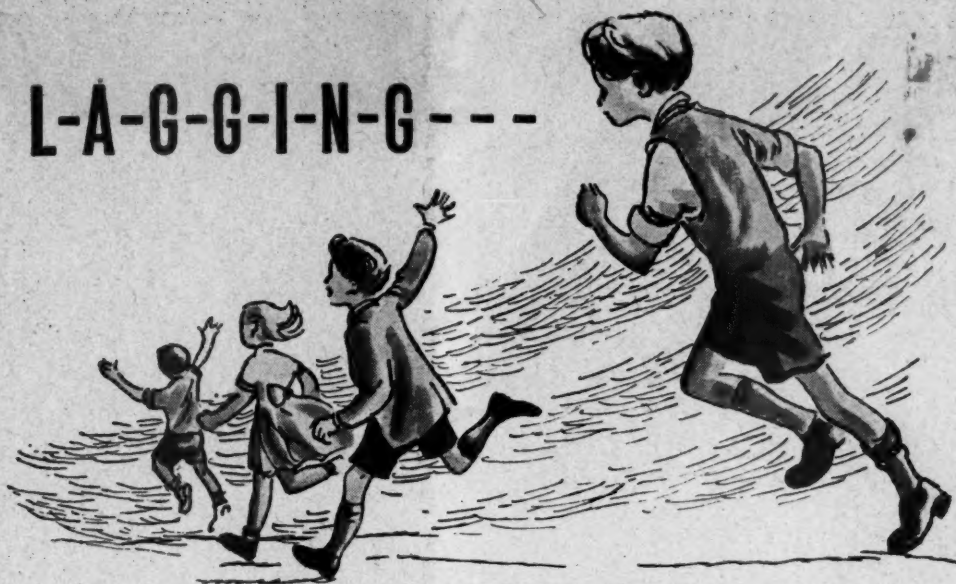




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